The Cosmetic Dental Center Of Baltimore

4 Reservoir Circle, Suite 100, Baltimore, Maryland 21208
410-486-5678

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #:_____

TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Larry A. Layton's office at above address or phone number.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date: _____

If this Consent is signed by a Guardian on behalf of the patient, complete the following:

Guardians' Name:_____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

The Cosmetic Dental Center Of Baltimore

4 Reservoir Circle, Suite 100, Baltimore, Maryland 21208
410-486-5678

NAME	AGE	M/F	TODAY'S DATE

BIRTHDATE	ADDRESS	CITY	STATE	ZIP CODE

HOME #	CELL #	WORK #	SOCIAL SECURITY #

EMAIL	DRIVER'S LICENSE #

PREFERRED WAY OF CONTACT	EMPLOYER	HOW LONG	OCCUPATION

DENTAL INSURANCE- NAME, ADDRESS, PHONE & GROUP #

PRIMARY INSURANCE SUBSCRIBER NAME AND EMPLOYER **DATE OF BIRTH**

MARITAL STATUS
S M W D

SIGNIFICANT OTHER'S NAME

EMERGENCY CONTACT **RELATIONSHIP** **PHONE**

WHO REFERRED YOU TO OUR OFFICE?

FINANCIAL POLICY
HALF WHEN SERVICE BEGINS, HALF UPON COMPLETION
FINANCIAL CONSULTATIONS UPON REQUEST

PAYMENT OPTIONS
CASH, CHECK, MONEY ORDER, VISA, MC, DISCOVER, AMERICAN EXPRESS

IT IS UNDERSTOOD THAT I, OR WE, WILL BE RESPONSIBLE FOR ALL CHARGES FOR PRESENT AND FUTURE SERVICES INCURRED ON THIS ACCOUNT REGARDLESS OF ANY INSURANCE COVERAGE THAT I/WE MIGHT HAVE. IN EVENT OF NON-PAYMENT, I AGREE TO PAY ALL COSTS OF COLLECTIONS, INCLUDING ATTORNEY'S FEES OF ONE THIRD OF ALL SUMS COLLECTED AND INTEREST ON THE ACCOUNT AT 18% PER ANNUM.

GUARANTOR'S SIGNATURE _____ **(SEAL)**

DATE _____

PATIENT'S NAME _____ **DATE OF BIRTH** _____

ANSWER THE FOLLOWING QUESTIONS YES OR NO

Physician's Name _____ Date of Last Physical _____
Address & Phone Number _____
Are you under a physician's care? ..... YES NO
Are you taking any medication? ..... YES NO
LIST ALL DAILY MEDICATIONS: (including aspirin & herbal supplements)

Are you allergic to any medications or substances? ..... YES NO
IF SO, PLEASE LIST _____
Do you have any other allergies? ..... YES NO
IF SO, PLEASE LIST _____
Do you have any problems with penicillin, antibiotics, anesthetics ..... YES NO
or any other medications?
Are you sensitive to metals or latex? If so circle metals / latex ..... YES NO
Are you pregnant or suspect that you may be? ..... YES NO
Do you use any birth control medications? ..... YES NO
Have you been treated or told that you have heart disease? ..... YES NO
Do you have a pacemaker or artificial heart valve implant? ..... YES NO
Have you ever had rheumatic fever? ..... YES NO
Do you have a heart murmur or mitral valve prolapse? ..... YES NO
Do you have high or low blood pressure? Circle if so - HIGH LOW ..... YES NO
Have you had a serious illness or major surgery? ..... YES NO
IF SO, PLEASE EXPLAIN _____
Have you had radiation treatment, chemo treatment or tumor, growth or any other condition? ..... YES NO
Do you have inflammatory disease, such as arthritis or rheumatism? ..... YES NO
Do you have artificial joints/prosthesis? ..... YES NO
If so what and when? _____
_____
Do you have any blood disorders such as anemia, leukemia etc.? ..... YES NO
Have you ever bled excessively after being cut or injured? ..... YES NO
Do you have any stomach problems? ..... YES NO
Do you have acid reflux? ..... YES NO
Do you have any kidney problems? ..... YES NO
Are you diabetic? ..... YES NO
Do you have asthma or any other respiratory disorders? ..... YES NO
Do you have epilepsy or seizure disorders? ..... YES NO
Do you have venereal disease? ..... YES NO
Have you tested HIV positive? ..... YES NO
Do you have AIDS? ..... YES NO
Have you had or do you test positive for hepatitis? ..... YES NO
Do you or have you had T.B. ..... YES NO
Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO
Have you had psychiatric treatment? ..... YES NO
Do you have any disease, condition, or problem not listed? ..... YES NO
IF SO, PLEASE EXPLAIN _____
Is there anything else we should know about your health not mentioned? ..... YES NO
IF SO, PLEASE EXPLAIN _____

I certify that the above information is complete and accurate.

Patient's / Guardian's Signature _____ Date _____

MEDICAL HISTORY

over ---->

DENTAL HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (CIRCLE YES OR NO)

COMMENTS

Bleeding gums while brushing or flossing ..... YES NO
Sensitivity to hot or cold liquids/foods..... YES NO
Sensitivity to sweet or sour liquids/foods..... YES NO
Pain in any of your teeth..... YES NO
Sores, lumps or swelling in the mouth..... YES NO
Food impaction..... YES NO
Dentures or partials ..... YES NO
Burning tongue ..... YES NO
Lip or mouth blisters ..... YES NO
Bad breath or unpleasant taste ..... YES NO
Tooth decay..... YES NO
Loose or broken fillings..... YES NO
Gag easily..... YES NO
Mouth breathing..... YES NO
Cheek, lip, fingernail biting ..... YES NO
Tired jaws ..... YES NO
Clicking of the jaw..... YES NO
Pain in jaw, joint, ear or side of face..... YES NO
Difficulty in chewing..... YES NO
Clenching teeth..... YES NO
Grinding teeth ..... YES NO
Frequent biting of your lip or cheek ..... YES NO
Prolonged bleeding following extractions ..... YES NO
Orthodontic treatment..... YES NO
Periodontal/gum treatment ..... YES NO
Loose teeth..... YES NO
Chew only on one side of mouth ..... YES NO
Dental implants..... YES NO

How many times a day do you brush your teeth? _____

What texture brush do you use? hard____ soft____ medium ____ (check one)

Do you use any of the following:

- Interdental stimulators ..... YES NO
- Water jet device..... YES NO
- Fluoride supplements ..... YES NO
- Mouthwash ..... YES NO
- If yes, what kind? _____
- Dental floss?..... YES NO

Are you satisfied with the appearance of your teeth? ..... YES NO
If No, Explain: _____

WHAT IS THE REASON FOR TODAY'S VISIT? _____

_____

DATE OF LAST DENTAL VISIT _____

Have you had dental X-rays within a year?..... YES NO

Signature _____