MM DENTISTRY

PATIENT REGISTRATION

Patient Information *(confidential)*

Date: _____/_____/_____

Name (First, MI, Last): _____ Preferred Name: _____
DOB:_____/_____/_____ Age:_____ SSN:_____-_____-_____ Gender: ☐ Male ☐ Female ☐ Other
Address:_____ City/State/Zip: _____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
E-mail: _____ Preferred Methods of Contact: ☐ Phone ☐ E-Mail ☐ Text
Emergency Contact/Relationship:_____ Emergency Phone:_____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Occupation:_____ Employment status: ☐ Part-time ☐ Full time ☐ Retired
Pharmacy Name: _____ Pharmacy Phone Number: _____
Whom may we thank for referring you? _____

Responsible Party *(complete if someone other than the patient)*

Parent/Guardian or Other:_____ Relationship to Patient:_____
DOB:_____/_____/_____ SSN:_____-_____-_____
Address:_____ City/State/Zip:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
E-mail:_____
Employer:_____ Occupation:_____
Is the responsible party a current patient in our office? ☐ Yes ☐ No

Insurance Information

Primary Policy Holder's Name:_____ Relationship to Patient:_____
Policy Holder's DOB:_____/_____/_____ Policy Holder's SSN: _____-_____-_____
Policy Holder's Employer:_____ Date Employed:_____
Work Phone Number:_____ Is this a Federal Plan? ☐ Yes ☐ No
Insurance Company:_____ Phone Number: _____
Group Number:_____ Policy/ID Number: _____

Secondary Policy Holder's Name:_____ Relationship to Patient:_____
Policy Holder's DOB:_____/_____/_____ Policy Holder's SSN: _____-_____-_____
Policy Holder's Employer:_____ Date Employed:_____
Work Phone Number:_____ Is this a Federal Plan? ☐ Yes ☐ No
Insurance Company:_____ Phone Number: _____
Group Number:_____ Policy/ID Number: _____

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Medical History

Patient Name (First, MI., Last):_____ Date of Birth: _____/_____/_____

Physician Name: _____ Phone: _____ Date of last visit: _____
Are you currently under a physician care? ☐ Yes ☐ No If yes, explain: _____
Have you had any serious illnesses, operations, or been hospitalized? ☐ Yes ☐ No If yes, please explain_____
Have you ever taken Phen-Fen/Redux? ☐ Yes ☐ No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐Yes ☐No
Medications you are currently taking (including over-the-counter): _____
_____
Do you use tobacco? ☐ Yes ☐ No If yes, What kind?_____ How many years? _____ How often?_____
Do you consume alcohol? ☐ Yes ☐ No If yes, How often?_____
Women Only:
Are you currently pregnant/possibly pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking oral contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following (leave blank if none):

☐ Aspirin	☐ Barbiturates	☐ Iodine	☐ Local Anesthetics	Other: _____
☐ Antibiotics (e.g. Penicillin)	☐ Codeine	☐ Latex	☐ Sulfa Drugs	

Check any of the following which applies to you (leave blank if none):

☐ AIDS/HIV Positive	☐ Drug Addiction	☐ Kidney Disease	☐ Sickle Cell Disease
☐ Alzheimer's Disease	☐ Epilepsy/Seizures	☐ Leukemia	☐ Sinus Troubles
☐ Anemia	☐ Excessive Thirst	☐ Liver Disease	☐ Skin Rash/Hives
☐ Angina	☐ Fainting Spells/Dizziness	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis or Rheumatism	☐ Frequent Coughs	☐ Lung Disease	☐ Stomach Intestinal Disease
☐ Artificial Heart Valve	☐ Genital Herpes	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joints/Replacements	☐ Glaucoma	☐ Osteoporosis	☐ Surgical Implant (s)
☐ Asthma	☐ Hay Fever/Seasonal Allergies	☐ Pacemaker	☐ Swelling of Limbs
☐ Back Problems	☐ Headaches/Migraines	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Bruise Easily/Bleeding	☐ Heart Attack/Failure	☐ Parathyroid Disease	☐ Tonsilitis
☐ Cancer	☐ Heart Disease	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Murmur/Irregular Beat	☐ Radiation Treatment	☐ Tumors or Growths
☐ Circulatory Problems	☐ Hemophilia	☐ Rapid Gain or Weight Loss	☐ Ulcers/Colitis
☐ Congenital Heart Disorders	☐ Hepatitis - Type : _____	☐ Respiratory Disease	☐ Venereal Disease
☐ COPD/Emphysema	☐ Herpes/Cold Sores	☐ Rheumatic Fever	☐ Other: _____
☐ Cortisone Treatments	☐ High Blood Pressure	☐ Scarlet Fever	☐ Comments: _____
☐ Diabetes Type (1 or 2) : _____	☐ High Cholesterol	☐ Shingles	_____

Dental History

Previous Dental Office/Location: _____ Date of Last Dental Exam/Cleaning: _____
Date of Last Dental X-Rays: _____ Are you in dental discomfort ?_____
Are you happy with the appearance of your teeth/smile? ☐ Yes ☐ No If no, explain_____
How often do you brush? _____ How often do you floss? _____
Have you ever had any adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No
If yes, please explain: _____

Check if you have had any of the following (leave blank if none):

☐ Bleeding Gums	☐ Grinding/Clenching teeth	☐ Prolonged bleeding after extractions
☐ Difficulty opening or closing of jaw	☐ Headaches	☐ Sensitivity to hot/cold/sweets
☐ Difficult extractions in the past	☐ Jaw pain/TMJ	☐ Sensitivity when biting/chewing
☐ Dry Mouth	☐ Loose/broken teeth or fillings	☐ Sores or growths in mouth
☐ Dental Anxiety/Fear	☐ Orthodontic Treatment	☐ Swollen tender gums
☐ Denture/Partials	☐ Periodontal (gum) Treatment	☐ Other: _____

To the best of knowledge, the questions on this form has been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient's Name (printed):_____ Date: _____/_____/_____

Patient/Parent/Guardian (print & signature): _____

Dr. Minh T. Ma, DDS • 5631 Burke Centre Pkwy Ste 2N, Burke, VA 22015 • (703) 425-4225 (phone) • (703) 425-7444 (fax)

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA). I understand that by signing this consent I authorize the practice, MM Dentistry, to use and disclose my protected health information to carry out:

- treatment (including direct or indirect treatment by other health care providers involved in treatment)
- obtaining payment from third party payers (e.g. insurance companies)
- the day-to-day healthcare operations

By signing this form, I understand that:

- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of the information, but I do not have to agree to those restrictions
- I have the right to revoke this consent in writing at any time, however, any use or disclosure that occurred prior to the date I revoke this consent is not affected
- The practice may condition receipt of treatment upon execution of this consent

I have also been informed of and given the right to review and secure a copy of the *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that MM Dentistry reserves the right to change the terms of this notice from time to time and that I may contact the practice at any time to obtain the most current copy of this notice.

Print Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

I approve releasing my information to the following people: (optional)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

MM DENTISTRY

Assignment and Release

I hereby authorize payment directly to MM Dentistry for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and services rendered to me or my dependents, whether paid or not paid by insurance. I authorize the doctor(s) and/or provider or supplier of services in this office to release any of my medical or financial information required to secure payment of benefits and to carry out any necessary treatment, payment activities, and health care operations. I authorize the use of this signature on all insurance submissions.

Financial Policy

I understand I am responsible for my total obligation should my insurance benefits result in less coverage than estimated. Insurance co-pays are general estimates. When payment from my insurance company is received and applied to my account, any balance due will be billed to me and any overpayment is refunded/credited to me. I understand payments must be paid in full at the time treatment is rendered. My account will be considered past due if not paid within 90 days of the initial bill. I also understand that I will be billed a $35.00 return check fee for any checks returned for insufficient funds. A 5% discount off the treatment plan is given to those who would like to pay in advance for their full treatment plan.

Office Policy

Cancellations/Missed appointments: I understand a minimum charge may be billed for missed or cancelled appointments without prior notification of 48 hours. I understand that failure to give a 48-hour notice that I cannot keep a reserved appointment may result in a missed appointment fee of $50.00 and, should this happen three (3) times, will result in dismissal from the practice. Our office reserves the right to refuse appointments for late cancellations as well as failure to attend. Please remember that once an appointment is made, this time is reserved especially for you as the patient.

X-rays/Radiographs: At our practice, we require all patients to have recent dental x-rays. Routine check-up x-rays are required once a year and full mouth x-rays are required every three (3) to five (5) years. This helps us accurately diagnose the current condition of your oral health. We understand there are concerns on radiation exposure; however, we keep an updated inspection of our x-ray machines to check for radiation leaks or malfunctions. We use the most current technology in digital dental x-rays which significantly reduces radiation. Ultimately, x-rays help the doctor diagnose any dental problems and a comprehensive exam is not complete without them. We are committed to helping you achieve and maintain healthy teeth and gums, so please allow us to update your dental x-rays or forward any recent dental x-rays in time for your visit.

Consent for Use/Disclosure of Health Information

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations. Your signature also indicates that you have had the full opportunity to read and consider our *Notice of Privacy Practices*, and that you understand that 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 on that notice. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you and/or continue treating you if you revoke this consent.

I, the undersigned, understand and agree to the policies stated above. I certify that the information on this form is accurate, to the best of my knowledge.

_____	_____	_____/_____/_____
Patient Name (Printed)	Patient/Guardian Signature	Date

Notice of Privacy Policy
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

USES AND DISCLOSURES OF HEALTH INFORMATION
The following describes how information about you may be used in this dental office:

- **Treatment Services:** We may use or disclose your health information to all of our staff members, other dentists, your physicians, and/or other health care providers taking care of you.
- **Payment and Health Care Operations:** We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
- **Marketing/Fundraising:** We will not use your health information for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.
- **Legal Requirements:** We may use or disclose your health information when required to do so by law.
- **Abuse or Neglect:** If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.
- **National Security:** When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may be provided to correctional institutes.
- **Family Members, Friends, and Others Involved in Care:** At your request, we may disclose your health information to a family member or other person if necessary, to assist with your treatment and/or payment for services. Based on our judgement and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.
- **Business Associates:** Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

- **Research:** We may use or disclose medical information to researchers when an institution's review board or special privacy board has reviewed the proposed study and established protocols to ensure the privacy of the health information used in their research and determined that the researcher does not need to obtain your authorization prior to using your medical information for research purposes.
- **Public Health Activities:** We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition; to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).
- **Other Authorizations:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
- **Breach Notification:** We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure.

PATIENT RIGHTS

- **Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information.
  We will charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.
- **Accounting of Disclosures:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We will keep your information confidential from your health plans if you pay cash, at your request. In some instances, we may not be required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
- **Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
- **Amendment:** You have the right to request that we amend your health information. (Your request must be in writing and must explain the reason for the amendment.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access to your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you may contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the HHS.