Barbara Bell DDS.PA

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PATIENT REGISTRATION

Patient Information. Please PRINT clearly. Thank you.

First name: _____Last name: _____Middle Initial: _____
Address: _____
City, State, Zip: _____
Home phone :(___) ____-_____Work phone: (____) ____-_____Cell: (___) ____-_____
Email address:_____
Birth Date: _____ Age: _____
Soc. Sec (required): _____
Sex: □ Male □ Female
Marital Status: □ Married □ Single □ Divorced □ Separated □Widowed
Employment Status: □ Full Time □ Part Time □ Retired
Name and Address of Employer:_____
Student Status: □ Full Time □ Part Time
Name of School:_____
Preferred Pharmacy:_____
How did you find our office? (Referral Source)_____
EMERGENCY CONTACT _____ Phone:(___) ____-_____

INSURANCE INFORMATION

Insurance Information (please provide insurance card)

Name of Policy Holder:_____Policy Holder Birth Date:_____
Relationship of patient: □ Self □ Spouse □ Child □ Other
Policy Holder SSN/ID (required):_____
Group number:_____
Subscriber's Address (if different than patient's):_____
Name of Policy Holder's Employer:_____City, State, Zip:_____
Name of Insurance Company:_____
Claims Mailing Address:_____

□ **Responsible party is also the Policy Holder for Patient**
□ Primary Insurance Holder
□ Do you have Secondary Insurance? (please provide secondary insurance card)

All questions on this form are important in arriving at a diagnosis and a treatment plan. If you do not understand a question or have a medical condition not mentioned on this form, it should be discussed with the doctor.

NAME:_____

CLINICAL INFORMATION:

Date Last Cleaning: _____ Last X-rays: (PAN/BWX)_____

What is your current dental problem: _____

_____

Name , address and telephone of previous dentist? _____

_____

Reason for changing dentist? _____

Name, address and telephone of current physician? _____

Are you being treated by any medical/dental specialists? Y/N If yes, please explain: _____

_____

Do you take pre medication before dental appointments due to implants, ie. hip, knee, breast? Y/N

If yes, please explain: _____

PAST & CURRENT HEALTH STATUS:

List current medications, including the **Name**, **Dosage**, and **Frequency** that you take: (use back if necessary)

_____

Have you been hospitalized in the past two years? Y/N If yes, please explain: _____

_____

Are you **allergic** to any medications? Have you had an unfavorable reaction from previous medical or dental treatment? _____If yes, please explain: _____

Do you smoke? Y/N If yes, how often?_____

Is there anything else about **your** past or current health history we should know: _____

_____

(continued next page)

Is there anything of importance in reference to your **family** history: _____

_____

Indicate if you had or have any of the following by circling:

Low Blood Pressure
High Blood Pressure
Heart Attack/Disease
Stroke
Heart Murmur
Lung Problems
Tuberculosis
Diabetes
Epilepsy/Convulsions
Kidney Problems
Cancer
Leukemia
Arthritis
Anemia
Radiation Cobalt
Prior Orthodontic
Lip Biting
Mouth Breather
Thumb/Finger Sucking
Hepatitis/Jaundice
Neuro-muscular Disease
Asthma or Hay Fever
Sinusitis
Thyroid Problems
Ulcers/Cold Sores
Rheumatic Fever
AIDS or HIV
Venereal Disease
Ear Infections
Excessive Bleeding
Excessive weight loss
TMJ Dysfunction
Periodontal Disease
Allergy to local Anesthetic (ie: Novocaine)
Clenching/Grinding Teeth
Treatment Nail Biting
Speech Difficulties
Play Musical Instrument
Auto-immune Disorder
Hip or Knee Replacement

WOMEN ONLY:

Are you pregnant? Y/N If yes, how many months?_____

Date of last Pap Smear _____ Any adverse findings, ie. HPV? Y/N

Are you currently being treated for or have a past history of breast cancer? _____

COSMETIC DENTISTRY/BOTOX/FACIAL MAKEOVERS:

Are you uncomfortable with the color of your teeth?	Y/N
Are you unhappy with the shape and appearance of your teeth?	Y/N
Are you uncomfortable with frown lines, crow's feet and/or a down turned mouth?	Y/N
Do your facial wrinkles age your appearance or make you look mean?	Y/N
Do you feel you look tired?	Y/N
Have you had previous cosmetic surgery?	Y/N

I understand that the information I provide on this form is essential to determine my dental needs and the provision of dental treatment. I understand that if any change occurs in my health, I am to report that change to the dental office as soon as possible. I have read and understand each question, and have answered all truthfully and to the best of my ability.

I hereby give consent to the dentist and or his/her designee for treatment and for the administration of medication and for the performance of diagnostic or treatment procedures she/he deems necessary. I understand that no guarantee of assurances have been made as to the results that may be obtained.

I hereby authorize Barbara Bell, DDS to furnish my insurance company all information which said company may request concerning my dental condition or injury. I agree that a photocopy of this authorization shall be considered equally authentic.

Patient / Guardian Signature:_____Date:_____

PATIENT FINANCIAL ACKNOWLEDGEMENT

Thank you for choosing Barbara Bell, PA as your dental care provider. We are committed to your treatment being a success. Our Insurance Department will work very hard to make sure paperwork is filed accurately and promptly.

WE ACCEPT ALL MAJOR CREDIT CARDS, CHECKS, CHECKCARDS and CASH.

Please understand insurance reimbursement can be a long and difficult process. In fact, insurers will routinely stall, deny, and reduce payments. Our office, as a convenience and service to you, will bill your insurance company on the date of your appointment. By Maryland State Law, insurance carriers have 30 days to expedite any claim. In the event that your insurance does not reimburse us within 45 days, we will transfer the balance to your account. Please Note: We do not accept assignment of auto related, medical or workman's compensation related claims.

HMO PLANS:

Our office is **NOT** in network with HMO Plans. Parties are responsible for their bill at the time of service.

PPO PLANS:

Please check with our office to verify if we are contracted with your group to accept the discounted rate.

SECONDARY INSURANCE PLANS:

We may bill your secondary insurance carrier but you will be responsible for waiting on reimbursement.

USUAL AND CUSTOMARY:

Our practice is committed to providing the best treatment for our patient and we charge what is usual and customary, provided by the insurance company.

DIVORCE DECREES/MINOR PATIENTS:

This office is **NOT** a party to your divorce decree. Adult parties are responsible for their bill at the time of service. The responsibility for minors rests solely with the accompanying adult. For accompanied minors, non-emergency treatment will be denied unless charges have been paid by a debit/credit card, cash or check at the time of service.

BROKEN APPOINTMENTS: (Please Initial on Line)

_____ We reserve the right to charge a fee of $75.00 for broken appointments.

LEGAL ASSIGNMENT: (Please Initial on Line)

_____ I, undersigned, understand that I am financially responsible for those charges not paid by my insurance company and agree that if upon default this matter is referred to an attorney for collection, the undersigned agrees to pay all attorney fees (up to 50% of unpaid balance)

RESUBMISSION FEES AND INTEREST: (Please Initial on Line)

_____ At the time of service all patients are responsible to update the office with current dental insurance. Patients will be responsible for a $30.00 resubmission fee or total cost of services rendered if claim is denied due to insufficient information. We are not a billing company. We reserve the right to charge interest in the amount of 24% APR.

The undersigned certificates that he/she has read and understands the foregoing paragraphs and is the patient or parent /guardian of the patient, or duly authorized to execute the above and accept its terms.

Patient Name: _____

Responsible Party/Guardian Signature: _____ Date: _____

BARBARA BELL, DDS, PA HIPAA Release Form

Notice of Privacy Practices.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form be kept confidential. The federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and /or leaving messages at home and /or at work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent we have already taken actions relying on your authorization.

For more information about our Privacy Practices, please contact our office.

I have reviewed Barbara Bell DDS, PA's Notice of Privacy Practices and understand that more information is available upon request. I also certify that I have read and understand the above information to the best of my knowledge. I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I also give Barbara Bell, DDS, PA permission to discuss or release my dental records to the names listed below. If no other individuals are to receive information, please place NONE in the spaces below.

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

Signature of Patient/Guardian_____Date_____

NO EXPIRATION UNTIL REQUIRED BY LAW