Towson Center for Dental Implants and Periodontics

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521 E. Joppa Rd., Suite 200 ● Towson, MD 21286
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REGISTRATION

Patient's Name_____ Date_____

Address_____ City_____ State_____ Zip Code_____

Telephone: Home_____ Work_____

Cellular_____ Fax_____ E-mail Address:_____

Emergency Contact_____ Phone_____ Relationship_____

Martial Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Minor _____

Date of Birth_____ Age_____ Social Security No._____

Employer_____ Occupation_____

Business Address_____ Business Phone No._____

Name of Spouse_____ Spouse's Employer_____

Spouse's Date of Birth_____ Spouse's Social Security No. _____

How did you hear about us?_____

General Dentist - Name and Phone number_____

Person Responsible for Payment of Account_____

Address, if different from above_____

Dental Insurance Company_____

Medical Insurance Company_____

Spouse's Dental Insurance Company_____

Spouse's Medical Insurance Company_____

Medical History

Physician's Name_____ Phone:_____ Date of last physical:_____

Please check all that apply:

☐ Any heart problems
___Valve Replacement
___Pacemaker
___Angina
___A-Fibrillation
___Heart Surgery
___Heart Attack

☐ High blood pressure
☐ Low blood pressure
☐ Circulatory problems
☐ Stroke
☐ Anemia
☐ Bleeding Disorder/ excessive bleeding
☐ Cancer/Malignancies
☐ Radiation treatments
☐ Chemotherapy
☐ Osteoporosis

☐ HIV/AIDS
☐ Kidney Problems
☐ Thyroid Problems
☐ Liver Problems
☐ Hepatitis ___A__B__C
☐ Intestinal Problems
☐ Ulcers
☐ Reflux
☐ Eating disorder
☐ Alcohol consumption How Much?_____
☐ Do you smoke? How Much?_____
☐ Organ Transplant_____
☐ Diabetes/Hypoglycemia
☐ Seizure Disorder/Epilepsy
☐ Asthma
☐ COPD
☐ Tuberculosis

☐ Psychiatric care
☐ Sinus Problems
☐ Herpes/Shingles
☐ Venereal Disease
☐ Arthritis
☐ Joint replacement Type:_____
☐ Osteoporosis
☐ Allergies to anesthetics _____
☐ Allergies to medicines or drugs_____
☐ Other Allergies:_____
☐ Recovering from Addiction:
____Alcohol
_____Drugs

☐ Are you pregnant? Due Date_____
☐ Blood Pressure : S_____/D_____

☐ Have you traveled to: Liberia, Guinea or Sierra Leone in the last 21 days?

☐ If yes, when did you return to the US?_____

☐ Are you feeling feverish?

OTHER SIDE PLEASE!

List current medications and dose(including vitamins, herbal and over the counter):_____

_____

_____

_____

_____

Preferred Pharmacy (name, location & phone #)_____

List all hospitalizations:_____

_____

_____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment._____

_____

Is there anything that you would like to discuss privately with the doctor?_____

_____

Patient Signature: _____ **Date**: _____

Doctors Signature:_____ **Date**:_____

OFFICE POLICY

We value you as a patient and strive to reserve appointment times that are convenient to your schedule. If you need to change the time that was reserved for you, please do so at least 48 business hours in advance. Surgical appointments not honored or changed with less than 48 business hours notice will be charged $300.00 and hygiene appointments will be charged the full provider fee for the scheduled service.

It is every patients' responsibility to provide correct dental benefit information. Towson Center for Dental Implants and Periodontics (TCDIP) will file insurance forms for you. By signing, patients covered under participating benefits plans authorize payments to be assigned to us, the providers of service. Payment of estimated co-payment is due at the time of service. Patients covered under non-participating benefit plans are expected to pay in full. Benefit reimbursements will be sent directly to patients.

Patients remain ultimately responsible for balances for services rendered. Patients must report changes to insurance information as soon as possible.

There will be a $35.00 returned check fee per item. Financing options are available in some instances. Patients using 3rd party financing must abide by terms set forth by the lender. Collection accounts will incur additional fees, court costs and attorney fees, if applicable. *If it becomes necessary to send my account to collection, I understand and agree that I will pay all collection costs, including but not limited to agency fees, court costs, the cost of a private process server if utilized, and reasonable attorney's fees.*

SIGNATURE: _____ Date:_____

TOWSONCENTER
dental implants & periodontics

James Kassolis, DDS Kathryn Mutzig, DMD Keyla Torres, DMD

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 IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.
- To maintain our facility directory. If a person asks for you by name, we will only disclose your name, general condition, and location in our facility. We may also disclosure your religious affiliation to clergy.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below**.**

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer:	Office Manager
Phone:	(410) 321-9477
Address:	521 E. Joppa Rd. Suite 200
	Towson, MD 21286
E-mail:	**office@towsonimplantsperio.com**

8. Effective Date. This Notice is effective January 1, 2013.

Acknowledgement

Patient Name (Printed) _____

Patient Name (Signature)_____

Date _____

Other persons authorized to have access to my Personal Health Information (please include relationship)

_____

_____

_____