Elegant Smiles
DENTISTRY

PATIENT INFORMATION FORM

LAST NAME: _____ FIRST NAME: _____ TITLE: _____

MIDDLE NAME: _____ PREFERRED NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

(H) PH: _____ (WK) PH: _____ (C) PH: _____

DOB: ____/____/_____ MARITAL STATUS: _____ SEX: M F

EMAIL: _____ SS#: _____-____-_____
(If you do not provide a SSN please provide us your drivers license)

EMERGENCY CONTACT (*specify someone who does not live in your household*)

NAME: _____ RELATIONSHIP: _____ PH #:_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PRIMARY INSURANCE COVERAGE (please notify front desk if you have secondary insurance)

POLICY HOLDER NAME AND ADDRESS:_____

RELATIONSHIP TO PATIENT: _____ SS#: _____-____-_____ DOB: _____/_____/_____

NAME OF EMPLOYER: _____

INSURANCE COMPANY PHONE #: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

POLICY HOLDER ID #: _____ GROUP#: _____

RESPONSIBLE PARTY FOR PATIENT

Print Name: _____

Signature: _____

Health History

Date of last dental appointment: _____ Physician's name & number_____ Date of last visit_____

Please circle if you have or have had any of the following:

Aids	Yes	No	Epilepsy	Yes	No	Psychiatric care	Yes	No
Anemia	Yes	No	Fainting or dizziness	Yes	No	Radiation treatment	Yes	No
Arthritis, Rheumatism	Yes	No	Glaucoma	Yes	No	Respiratory disease	Yes	No
Artificial heart valves	Yes	No	Headaches	Yes	No	Rheumatic fever	Yes	No
Artificial joints	Yes	No	Heart murmur	Yes	No	Scarlet fever	Yes	No
Asthma	Yes	No	Heart problems	Yes	No	Shortness of breath	Yes	No
Back problems	Yes	No	Hepatitis (Type)_____	Yes	No	Sinus trouble	Yes	No
Bleeding abnormally	Yes	No	Herpes	Yes	No	Skin rash	Yes	No
Blood disease	Yes	No	High blood pressure	Yes	No	Special diet	Yes	No
Cancer	Yes	No	High Cholesterol	Yes	No	Stroke	Yes	No
Chemical dependency	Yes	No	HIV positive	Yes	No	Swelling (feet/ ankles)	Yes	No
Chemotherapy	Yes	No	Jaundice	Yes	No	Swollen neck glands	Yes	No
Circulatory problems	Yes	No	Jaw pain	Yes	No	Thyroid problems	Yes	No
Congenital heart lesions	Yes	No	Kidney disease	Yes	No	Tonsillitis	Yes	No
Cortisone treatments	Yes	No	Liver disease	Yes	No	Tuberculosis	Yes	No
Cough, persistent or bloody	Yes	No	Low blood pressure	Yes	No	Tumor/ growth head or neck	Yes	No
Diabetes	Yes	No	Mitral valve prolapse	Yes	No	Ulcer	Yes	No
Emphysema	Yes	No	Nervous problems	Yes	No	Venereal disease	Yes	No
Do you wear contact lenses?	Yes	No	Pacemaker	Yes	No	Weight loss, unexplained	Yes	No
						Women: Are you pregnant?	Yes	No
						Due date_____		
						Are you nursing?	Yes	No

List medications you are currently taking:

Pharmacy name:_____ Pharmacy phone:_____

Allergies to:

Aspirin	Yes	No	Local Anesthetic	Yes	No	Barbiturates (sleeping pills)	Yes	No
Codeine	Yes	No	Sulfa	Yes	No	Iodine	Yes	No
Penicillin	Yes	No	Latex	Yes	No	Other _____		

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

Signature_____ Date _____

MEDICAL UPDATES:

DATE	*EXCEPTIONS*	*PATIENTS SIGNATURE*	*REVIEWED BY*

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DENTISTRY

ABOUT FINANCIAL ARRANGEMENTS, DENTAL INSURANCE & FEES

WE ACCEPT: MC, VISA, DISCOVER, AM EX, CASH, CHECKS & CARE CREDIT

We are committed to providing you with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of your Insurance Benefits.

PAYMENTS FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED. PAYMENTS INCLUDE CO-PAYMENTS, AND DEDUCTIBLES OR THE BALANCE IN FULL IF YOU DO NOT HAVE INSURANCE COVERAGE. Also, if your insurance company for some reason does not pay as we expected, then you are responsible to pay the balance in full as soon as you are notified by us or the insurance company.

IF FOR ANY REASON, YOU HAVE A BALANCE IT MUST BE PAID IN 10 BUSINESS DAYS TO AVOID A $10 LATE FEE FOR EVERY STATEMENT.
IN THE EVENT OF A BREACH IN THIS AGREEMENT, COURT COST AND ATTORNEY'S FEES WILL ALSO BE ASSESSED.

A $50.00 FEE WILL BE ADDED TO YOUR ACCOUNT FOR *BROKEN APPOINTMENTS OR *SAME DAY CANCELLATIONS.
If you need to cancel an appointment please call 24 hours in advance of your appointment. If you need to cancel and the office is closed please leave a message on our machine to avoid a $50.00 fee.

***<u>If 3 appointments are missed/broken we have the right to no longer see you in our office for dental services</u>.**

PLEASE UNDERSTAND THAT:
<u>YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT.</u>
We must emphasize that as Dental Care Providers our relationship is with you not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.**

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE DON'T HESITATE TO ASK US. WE ARE HERE TO HELP YOU.

_____ _____
PATIENT OR GUARDIAN SIGNATURE DATE

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Informed Consent Local Anesthesia

I understand that my dental treatment may require the use of a local anesthetic for pain control. I understand that a local anesthetic may consist of different medications that are injected into the cheek or gum area. These drugs may include prilocaine, mepivacaine, bupivacaine, articaine, or others. Many people refer to local injections as "Novocain" however; this particular drug is seldom used because newer medications are more effective, longer lasting and less likely to cause allergic problems. I understand that local anesthetics may contain a "vasoconstrictor" like epinephrine antioxidants such as sulfites or methyl paraben for preservation of the solutions sodium hydroxide and sodium chloride.
I understand that local anesthetics will cause a section of my mouth to become numb, with the numbness lasting from a few minutes to several hours. I know that while my mouth is numb I must be careful not to bite my lips or tongue.
Local anesthetics are among the most common drugs used in a dental office. Complications and side effects are rare but may include, among others not listed on this sheet:

- Swelling, bruising, or soreness at the injection site.
- A blood filled swelling, called hematoma, which can form when a needle is used during an injection, hits a blood vessel.
- Numbness (temporary) outside of the mouth making an eyelid or mouth "droop"
- Temporary rapid heartbeat.
- Damage to the nerves resulting in temporary or possibly permanent numbness or tingling of lips, chin, tongue or other areas.
- Severe allergic and possible life threatening reactions necessitating emergency care.

I understand that if I have uncontrolled high blood pressure, uncontrolled thyroid problems, angina or have recently had a heart attack that I will inform my dentist without fail as these conditions have caused complications for persons receiving local anesthesia. I will also inform the dentist of any prescription or over-the-counter medications I am taking as these may interact with local anesthetics. I understand the recommendation of local anesthetic for my treatment, any fee involved, risks of treatment, any alternatives and risks of these alternatives, including consequences of doing nothing.

I also give my consent for dental treatment including dental exam & radiographs (x-rays)

I have had all of my questions answered and have not been offered any guarantees.

_____ _____

Patient or Guardian Signature Date

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 this notice carefully and acknowledge receipt by your signature at the end of this notice.

This notice describes how PGN Dental LLC may use and disclose your protected health information. PGN Dental LLC will share patient health information as is necessary to provide quality health care. PGN Dental LLC is required by law to maintain the privacy of our patient's health information and to provide patients with this notice so long as it remains in effect and we reserve the right to change the terms of this Notice of Privacy Practices as necessary. A copy of any revised notices will be mailed to your address maintained on file.

Uses and Disclosures of your Health information

PGN Dental LLC is committed to maintain the confidentiality of your health information. However, your health information may be used and disclosed is customary and reasonable for purposes of treatment, payment and health care operations and pursuant to a signed authorization form. You have the right to revoke that authorization in writing unless any action has been taken in reliance on the authorization.

Treatment, Payment and Health Care Operations

(Except as otherwise provided, or with your signed consent) PGN Dental LLC will use and disclose your health information for purposes of treatment, payment and as otherwise necessary and permitted by law, for our health care operations. This may include disclosure to other health care providers who, at the request of your physician, becomes involved in your treatment.

Business Associates

At times, it may be necessary for us to provide your health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your health information.

Family and Friends

With your approval and using our professional judgment, your health information may be disclosed to designated family, friends and others who are directly involved in your care or payment of your care. If you are unavailable, incapacitated, or in an emergency medical situation and we determine that a limited disclosure may be in your best interest we may share limited health information with such individuals without your approval.

(Please list those people with whom we are permitted to discuss your dental information)

_____, _____, _____

When your information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by federal HIPPA Privacy Rule. You have the right to revoke this authorization in writing except when PGN Dental LLC has acted in reliance upon this authorization. Your written revocation must be submitted to our office at 14420 Old Mill Road Suite 101, Upper Marlboro, MD 20772

_____	_____	_____
Printed name of patient	Signature of patient or guardian	Date