Annapolis Periodontics

Practice Limited to Periodontics and Implant Dentistry

Deborah A. Odell, D.D.S., PC

Angela M. Miele, D.M.D.

Dr. Maria Tibbs, D.D.S., M.S.

2448 Holly Avenue, Suite #202

Annapolis, MD 21401-3148

Office #: 410-224-0500 Fax #: 410-224-6039

www.annapolisperiodontics.net

PATIENT NAME: _____

(FIRST) (MIDDLE) (LAST)

Preferred Name or Nickname:_____

Birth Date :_____ Sex: M F Marital Status: S M D W

Address: _____ APT #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ SS #: _____

E-Mail Address: _____

Employer's Name: _____ Occupation: _____

Employer's Address: _____ Full Time Student: Y N Grade_____

Has any member for your family ever been treated in our office? Y N

Whom may we thank for referring you to our office? _____

PERSON RESPONSIBLE FOR THIS ACCOUNT *(If different from above)*

Relationship to Patient: ( ) Spouse ( ) Parent / Guardian ( ) Other _____

Name: _____ Birth Date: _____ Sex: M F

Address: _____ APT #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ SS #: _____

IS THE PATIENT COVERED BY DENTAL INSURANCE? ( )YES ( )NO

If no, skip to next page

Insurance Company Name: _____ Group #: _____

Claims Mailing Address: _____

Insurance Phone: (_____)_____ Policyholder's ID #: _____

Policyholder's Name: _____ DOB: _____

Policyholder's SS #: _____ Policyholder's Phone: (_____)_____

Policyholder's Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

Employer's Name: _____

Employer's Address: _____

Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent / Guardian ( ) Other _____

DOES THE PATIENT HAVE SECONDARY DENTAL INSURANCE? ( )YES ( )NO

Insurance Company Name: _____ Group #: _____
Claims Mailing Address: _____
Insurance Phone: (_____)_____ Policyholder's ID #: _____
Policyholder's Name: _____ DOB: _____
Policyholder's SS #: _____ Policyholder's Phone: (_____)_____
Policyholder's Address: _____ Suite #: _____
City: _____ State: _____ Zip Code: _____
Employer's Name: _____
Employer's Address: _____
Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent / Guardian ( ) Other _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Relationship to Patient: ( ) Spouse ( ) Parent / Guardian ( ) Other _____
Name: _____ Birth Date: _____ Sex: M F
Address: _____ APT #: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (_____)_____ Work Phone: (_____)_____
Cell Phone: (_____)_____

TREATMENT AUTHORIZATION

I hereby authorize Annapolis Periodontics, Drs.' Odell, Miele, and Ward to administer such medications and perform such diagnostic, therapeutic and surgical procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are true to the best of my knowledge. I also understand it is very important to report any changes in my medical or dental status to my provider at the earliest possible time, and I agree to do so.

Signature: _____ Date: _____

PAYMENT AUTHORIZATION

I hereby authorize payment directly to Annapolis Periodontics, Drs.' Odell, Miele and Ward of the group insurance benefits otherwise payable to me. Due to the constantly changing insurance rules and regulations, benefits and deductibles, the Dental Office is only able to approximate your out-of-pocket expenses for your dental treatment. Your dental insurance benefits are based upon a contract between you and your employer and the insurance company, not our office. If your insurance pays more than expected, you will be reedited the difference. I understand that if payments are not received by the agreed upon dates, a finance charge may be added to my account after 90 days of the date of service in addition to any collection or attorney fees. I authorize the use to my social security number to file my dental claim and understand that if one is not provided to the office, payment in full will be collected at each visit. Payment is expected at time of service and cancellation or failure to keep a scheduled appointment without a 48 hour notice may result in a charge for the time reserved for you. It is important for you to understand that you are personally responsible for all charges that you or a dependent may incur in the office. I understand and accept final responsibility for all costs incurred.

Signature: _____ Date: _____

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Patient Name: _____ Date: _____

Medical Physician Name: _____ Physician Phone: (____)_____

Physician Address/Location: _____

Date of Last Medical Exam: _____

Are you now or have you ever been under a physician care? ( )NO ( )YES Explain:_____
Have you been out of the United States in the past 45 days? ( )NO ( )YES Explain:_____
Have you ever had to Pre-Medicate prior to a dental appointment? ( )NO ( )YES Explain:_____
Have you ever had or currently have the following conditions:

__ Abnormal Bleeding
__ Alcohol Abuse
__ Allergies
__ Anemia
__ Arthritis
__ Asthma
__ Blood Transfusion/Disease
__ Cancer/Chemotherapy
__ Diabetes
__ Emphysema
__ Epilepsy
__ Fainting Spells
__ Glaucoma
__ Hay Fever
__HIV / AIDS
__Heart Problems
__Heart Murmur / MVP
__Heart Valve Replacement
__Hepatitis
__High Blood Pressure
__Joint Replacement
__Kidney / Bladder Problems
__Liver Disease
__Low Blood Pressure
__Lung Disease
__Pace Maker
__Prolonged Bleeding
__Psychiatric Problems
__Pre-Medicate
__Radiation Therapy
__Rheumatic Fever
__Shortness of Breath
__Sickle Cell Disease
__Sinus Problems
__Thyroid Problems
__Tuberculosis
__Ulcers
__Unable to Give Blood
__Venereal Disease
__ Other _____
_____
_____

Are you taking any medication on a routine basis? (Over the counter medication, birth control, shots, implant, hormone therapy, etc.) Please list: _____

_____

Do you smoke or use tobacco? ( )NO ( )YES How much? _____
Check any of the following that you are taking or have taken:
__Cortisone Drugs __Anticoagulants __Tranquilizers __Fosamax __Blood Thinners
__Steroids __Sedatives __Bisphosphonates

Are you allergic to or do you suffer ill effects from any of the following?
__Penicillin __Codeine __Dental Anesthesia __Aspirin __Household Bleach __Latex Products
__Metals __Other _____

FEMALE: Are you pregnant? ( )NO ( )YES How many Months? _____ Breast Feeding? ( )NO ( )YES

The above information is true to the best of my knowledge.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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My Signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Heath Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide to such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent / Guardian ( ) Other _____

Dependent family members also covered by this acknowledgement: _____
_____
_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reason:

- The patient refused to sign
- Communication Barriers
- Emergency Situation
- Other _____

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Cancellation Policy

1. *Cancellation / No Show Policy for Doctor Appointment* $75.00

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, if an appointment is not cancelled at least 48 business hours in advance you will be charged a seventy five dollar ($75) fee for a missed hygiene visit.

2. *Cancellation / No Show Policy for Surgery* $250.00

If surgery is not cancelled at least three (3) business days in advance, you will be charged a fee of $250. This is NOT covered by your insurance company.

3. *Account Balances*

Patients with self pay balances are required to pay their account balances to zero (0) prior to receiving further services by our practice. Patients are encouraged to put a credit card on file for these payments.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to an office manager with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____	_____	____ / ____ / ____
Print Patient Name	**Signature Patient / Guardian**	**Date**

(Office Use Only) **Patient Account # _____**

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Since your last visit to our office (or if you are a new patient) have you begun taking Bisphosphonates or other bone modifying drugs?

Such as: Fosamax, Boniva, Zometa, Xgeva, Atelvia etc.

If so, please provide start date and medication name

( ) No, I am not taking Bisphosphonates

Your Name: _____

Date: _____

( ) Yes, I am taking Bisphosphonates

Your Name: _____

Date started drug: _____

Name of drug: _____

Date of last use or injection: _____

Signature:_____ **Date:** _____