Oasis Dental

PATIENT REGISTRATION FORM

Section I Patient Information

Date___/____/_____

Name: _____ I Prefer to be called: _____

Address: _____City: _____State: _____Zip: _____

Phone: (_____)_____ Work Phone: (_____) _____ Cell Phone: (_____)_____

Email Address_____

Date of Birth: ___/___/_____ Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Name of Employer or School: _____ City/State: _____ ☐ FT ☐ PT

Spouse or Parent's Name: _____ Employer: _____ Work Phone: (____)_____

Whom may we thank for referring you? _____

Emergency contact: _____Relationship: _____Phone: (____)_____

Section II Responsible Party

Relationship to Patient: ☐ Self (if self, you don't need to complete this section) ☐ Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____)_____

Employer: _____ Work Phone: (____)_____

Section III Dental Insurance Information

Name of Insured: _____ DOB___/____/_____Relationship to Patient: _____

Name of Employer:_____ Insurance Company: _____

Group #_____ ID# OR SSN#_____

Ins Co Address: _____ Ins Co. Phone: (____)_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? IF YES, COMPLETE THE FOLLOWING

Name of Insured: _____DOB___/____/_____Relationship to Patient: _____

Name of Employer: _____ Insurance Company: _____

Group #_____ ID# OR SSN #_____

Ins Co. Address: _____ Ins Co. Phone: (____)_____

Dental Information

Previous dentist_____ Last Dental Visit: ___/____/_____Last Dental Cleaning: ___/____/_____

How often do you brush? _____How often do you floss? _____

What made you decide to schedule this dentist appointment? _____

HEALTH HISTORY

Do you require pre-medication for dental treatment? Yes ☐ No ☐ Reason: _____ Type: _____

Please list any allergies to medications: _____

Please list any other allergies: _____

CURRENT MEDICATIONS (PRESCRIPTIONS, OVER THE COUNTER & HERBAL)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

PAST AND CURRENT MEDICAL CONDITIONS (PLEASE MARK ALL THAT APPLY)

Under the care of a physician? Details: _____		Lung disease? TYPE: _____	
Hospitalization/operations in the last 5 years? Details: _____		Radiation treatment of head/neck? WHEN: _____	
Women: Pregnant? _____ Nursing?_____		Chemotherapy? WHEN: _____	
Women: Oral contraceptives?		Arthritis or other joint disorder? TYPE: _____	
History of Cancer? TYPE:_____		Fibromyalgia?	
High Blood Pressure?		Diabetes? TYPE: _____ Controlled? Y N	
Heart Disease? TYPE: _____		Depression: Diagnosed?	
Heart Surgery? TYPE: _____		Other psychiatric disorders? TYPE: _____	
Artificial heart valves?		Epilepsy/seizures?	
History of Organ Transplant?		Stomach: Reflux? _____ Ulcer? _____	
Thyroid disease? TYPE: _____		Sjogrens Disease?	
Artificial joints? TYPE: _____WHEN:_____		Headaches?	
Stroke? DATE: ___/___/_____		Hepatitis?	
Bleeding problems? TYPE: _____		AIDS? HIV positive?	
Anemia?		Alcohol/chemical dependency?	
Asthma?		Other:	

TOBACCO

Are you or have you ever been a tobacco user?_____If so, how many years?_____ how often?_____Quit date_____

PAST DENTAL TREATMENT (PLEASE MARK ALL THAT APPLY)

Do you have a family history of extensive decay?		Have you had treatment for periodontal (gum) disease?	
One or more fillings in the last three years?		Have you had treatment for temporomandibular disorders (TMJ)?	

DO YOU HAVE CONSISTENT PROBLEMS WITH: (PLEASE MARK ALL THAT APPLY)

Dry mouth/excessive thirst?		Mouth odors/bad taste?		Teeth/filling break frequently?		Clenching or grinding habits?	
Tooth sensitivity to? Hot cold pressure sweets		Sore, bleeding gums?		Food catches between teeth?		Difficulty chewing?	
Loose teeth?		Are you nervous about dental work? Details:					

PLEASE SIGN BELOW:

PRINT NAME:	SIGNATURE:	Date:

Oasis Dental

OFFICE POLICIES

Welcome! Thank you for selecting Oasis Dental as your dental health care provider. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to be involved with all aspects of your dental care starting with being well informed. This includes understanding our policies.

Appointments

Please understand that arriving late for your scheduled appointment time may result in the rescheduling of your appointment. We do ask for 24 hours notice to reschedule or cancel an appointment. The charge for lack of notice or a missed appointment is $25. **Dr. Gherman reserves the right to dismiss a patient from the practice if a patient has repeated broken or missed appointments.**

Financial Agreement

Our goal is to offer you payment options to finance the care you need to maintain good oral health while staying within your budget.

Whenever possible, an estimate of out of pocket cost will be provided prior to treatment. All estimated out of pocket costs are due at the time of service. We accept all major credit cards, check and cash payments.

Extended Payments: *For patients who desire a monthly payment plan, we have made arrangements with CareCredit. Please ask any of our staff members for additional information, a brochure or application if interested.*

Dental Insurance: *As a courtesy, we will file your insurance, speak on your behalf to the insurance company and accept any assignment of benefits that your insurance company will allow. We will estimate your patient portion by considering the information provided by your insurance company. The insurance company will not guarantee payment; therefore all patients are directly responsible for all charges.*

Collection Fees: *A $30 fee will be charged for all returned checks. Accounts with balances over 30 days will be subject to late fees in the amount of 2% on a monthly basis. All accounts with balances of 90 days will be turned over to Collections and subject to additional fees for the collection services. For all patients under the age of 18, the legal guardian presenting the patient for treatment is responsible for all payments to Oasis Dental. This office does not participate in any agreements between parents or other parties. We will be happy to provide receipts and ledgers for any charges and payments.*

Authorization and Consent

I agree that I have filled out these forms with the intent of honesty and I agree that it is my own responsibility to update any changes in my medical history and or conditions with each dental visit.

General Consent for Treatment: I agree and consent to a dental examination by dentist(s) practicing under the name Oasis Dental. I understand that additional diagnostic procedures and treatment may be recommended and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatment.

Release of Information: I authorize Oasis Dental to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other health professionals.

Assignment of Insurance Benefits: I authorize and request my insurance company to pay my benefits directly to Oasis Dental.

Photography Release: I authorize Oasis Dental to take photographs of me to help me better understand my current dental condition and possible treatment options.

Receipt of Privacy Policies: I acknowledge that I have received a copy of Oasis Dental's Notice of Privacy Practices.

_____ _____ _____

Patient Name (please print) ***Signature of Patient, Parent or Guardian*** ***Date***

Oasis Dental

HIPAA Representative Form

THIS FORM NEEDS TO BE COMPLETED IF YOU WISH TO ALLOW ACCESS TO YOUR PERSONAL HEALTH INFORMATION. (THIS INCLUDES BUT IS NOT LIMITED TO SPOUSES, PARENTS, AND OTHER FAMILY MEMBERS). YOU MAY DECLINE SELECTING A HIPAA REPRESENTATIVE.

Patient Information – Please Print: Patient Name: _____ DOB:____/____/____

_____**I decline to select a HIPAA Representative.**
(please sign at the bottom of this page.)

_____**I wish to select a HIPAA Representative.**
(Please complete all information below)

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the HIPAA Representative named below to have authority to access to my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below:

HIPAA Representative Information: Please Print:

Name:_____ DOB:___/____/_____ Relationship:_____

Address:_____ Phone:_____

Name:_____ DOB:___/____/_____ Relationship:_____

Address:_____ Phone:_____

Name:_____ DOB:___/____/_____ Relationship:_____

Address:_____ Phone:_____

I grant to the HIPAA Representative named above access to:

___All of my personal health information- note separate box below is also required for HIV, psychiatric and substance abuse access.

___Other- Specify Limits or specific health care incident_____

By checking the appropriate categories and by signing this box I (patient) am granting my HIPAA Representative access to additional health information:

I understand that this health information may include HIV- related information and /or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this box, I am specifically authorizing my HIPAA Representative access to information relating to:

____Substance Abuse (including alcohol/drug abuse)
____Mental health
____Psychotherapy Notes
____HIV related information (including AIDS related testing)

This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Signature of Patient for this box: _____ Date: ____/___/_____

1. I understand that I may revoke this HIPAA Representative designation at any time by notifying Oasis Dental in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Oasis Dental prior to their receipt of the revocation.

2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.

3. I understand that information disclosed pursuant to this form may be re-disclosed by the recipient and no longer protected by HIPAA.

4. I understand that this Authorization will be effective for the lifetime of the patient unless revoked (see #1 above)

Signature of Patient: _____ **Date:** _____
(Form will not be valid unless all appropriate blanks are filled)

OASIS DENTAL

NOTICE OF PRIVACY PRACTICES

(You may keep this document for your records)

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 PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 08/01/2012, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

- **Your Authorization:** 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 an authorization, you may revoke it in writing 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.

- **To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

- **Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

- **Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

- **Required by Law:** We may use or disclose your health information when we are required to do so by law.

- **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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 may charge you a reasonable cost based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting: 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, but not before April 14, 2003. 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 are not 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 it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at the address and phone number provided on our website (www.oasisdentalmd.com)

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services.

Contact Officer: Adrian Gherman Telephone: 410-776-3168 Fax: 443-371-7753 E-mail: oasisdentalmd@gmail.com

Address: 602 South Atwood Road, Suite 101C, Bel Air, Maryland 21014