Kenneth A. Film, DDS
708 Chase Six Blvd Boonsboro, MD 21713
301-432-4322 info@southmtndental.com

Welcome! *Thank you for choosing our office for your dental needs. To help us meet all your needs, please fill out this form as completely as possible. If you need help or have any questions, please ask. Thank you.*

Today's Date _____

Patient Information (Confidential)

Last Name _____ *First Name* _____ *MI* _____ *Gender* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Cell Phone _____ *Work Phone* _____ *Home Phone* _____

Birthday _____ *Social Security Number* _____

Email _____

Emergency Contact _____ *Phone* _____ *Relationship* _____

Marital Status ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed*

Employment Status ☐ *Student* ☐ *Employed* ☐ *Not Employed* ☐ *Retired*

Employer _____ *City, State* _____

Dental Insurance Information

Insurance Subscriber _____ *Relationship* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Cell Phone _____ *Work Phone* _____ *Home Phone* _____

Birthday _____ *Social Security Number* _____

Employer _____ *City, State* _____

Insurance Company _____ *Phone* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Member/Subscriber ID Number _____ *Group Number* _____

Referral Information

How did you hear about our office? ☐ *Current Patient (who?)* ☐ *Post Card* ☐ *Internet* ☐ *Drive-by* ☐ *Other*

If other, how? _____

Patient Health History

Physician _____ Office Phone _____ Last Exam _____

Pharmacy _____ Street and City _____

	YES	NO
1. Are you under medical treatment now?.....	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?.....	☐	☐
3. Are you taking any medications, including non-prescription medicines?.....	☐	☐
If yes, what are you taking? _____		
4. Do you use tobacco?.....	☐	☐

5. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO ANY OF THE FOLLOWING?	YES	NO
Codeine…….....	☐	☐
Dental Anesthetics.....	☐	☐
Erythromycin.....	☐	☐
Latex.....	☐	☐
Metals.....	☐	☐
Penicillin.....	☐	☐
Tetracycline.....	☐	☐
Other _____	☐	☐
6. WOMEN ONLY:	YES	NO
Are you pregnant or could you be pregnant?.....	☐	☐

7. Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
Abnormal Bleeding……..…..	☐	☐	Heart Disease…….……	☐	☐	Respiratory Disease……..	☐	☐
Allergies (seasonal).....…..	☐	☐	Heart Murmur……...	☐	☐	Rheumatic Fever…….…….....	☐	☐
Alzheimer's…….....	☐	☐	Hepatitis (Type? _____) …	☐	☐	Sexually Transmitted Disease….	☐	☐
Anemia…….....	☐	☐	High Blood Pressure…..……	☐	☐	Sinus Problems……...	☐	☐
Angina……	☐	☐	HIV/AIDS……	☐	☐	Sleep Apnea……...……	☐	☐
Asthma…….....	☐	☐	Joint Replacement……..……	☐	☐	Stroke……...……	☐	☐
Autism Spectrum Disorder..	☐	☐	Kidney Disease……...	☐	☐	Thyroid Problems……..……..	☐	☐
Diabetes……..	☐	☐	Liver Disease……..…	☐	☐	Tuberculosis……	☐	☐
Emphysema……..……	☐	☐	Low Blood Pressure……...	☐	☐	Ulcers/Stomach Problems……	☐	☐
Epilepsy……..	☐	☐	Pacemaker……...	☐	☐	Other _____	☐	☐
Fainting……...	☐	☐	Radiation Therapy……....	☐	☐	Other _____	☐	☐

Patient Dental History

Reason for today's visit: _____

Date of Last Exam: _____ Date of Last X-rays: _____ Former Dentist: _____

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

Please check any of the following that apply to you:

☐ Bleeding gums	☐ Grinding teeth	☐ Prolonged bleeding following extractions
☐ Bad breath	☐ Clicking or popping jaw	☐ Pain on chewing or biting
☐ Periodontal treatment	☐ Food collecting between teeth	☐ Sores or growths in your mouth
☐ Snoring	☐ Frequent headaches	Sensitivity to: ☐ Hot ☐ Cold ☐ Sweets

Authorization and Release

I certify that I have read and understand the above information, to the best of my knowledge. I have answered the above questions as accurately as possible. I understand that providing incorrect information can be dangerous to my health. I authorize South Mountain Dental to release any information, including the diagnosis and/or records of any treatment or examination rendered to my dependent or me during the period of such dental care, to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree that I am ultimately responsible for payment of all services rendered on behalf of my dependents or myself, including any services for which my insurance does not pay or pays less than expected.

Patient Signature _____ Date _____

(or Parent/Guardian, if minor)

South Mountain Dental, LLC
301-432-4322
info@southmtndental.com

Financial Policy

effective 9-1-15

708 Chase Six Blvd
Boonsboro, MD 21713

Missed Appointments & Cancellations:

Please give our office at least 48 hours notice for any cancellations. If we do not have at least 48 hours notice, we may charge a $75 Missed Appointment and Cancellation fee. The fee will need to be paid before a new appointment can be scheduled. If a patient misses 3 appointments, they may be asked to transfer their records to another dental office.

Insurance:

Our goal is to maximize your insurance benefits. We are in-network with non-HMO Cigna Dental Plans and any plans that utilize Cigna Claim Payment Services. For all other insurance plans, we are out-of-network. As such, your dental insurance is a contract between you and your insurance company. We are not a part of this contract. We will bill your insurance as a courtesy to you. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and payment. You agree to pay any portion of the charges not covered by insurance for receiving services.

Payment Options, if you have no insurance:

1. You must pay (by cash, check, or credit card) your total cost at the end of any appointment in which services are rendered.
2. You may pay in full in advance. Since it requires less administration on our part, should you choose this option we will extend a 5% discount on the amount you pay in advance
3. We offer special financing through CareCredit. CareCredit offers 6 or 12 month deferred interest plans or extended plans with interest. Information is available at www.carecredit.com or by contacting our office.
4. We may offer you an automatic payment plan, at our discretion.

Payment Options, if you have insurance:

1. You must pay (by cash, check, or credit card) your deductible and any out-of-pocket estimates at the end of the appointment in which services are rendered.
2. You may pay in full in advance (or your estimated co-payment if part of your treatment will be covered by insurance). Since it requires less administration on our part, should you choose this option we will extend a 5% discount on the amount you pay in advance.
3. We offer special financing through CareCredit. CareCredit offers 6 or 12 month deferred interest plans or extended plans with interest. Information is available at www.carecredit.com or by contacting our office.
4. We may offer you automatic payment plans, at our discretion.

Monthly Statement:

If you have a balance on your account, we will send a monthly statement. It will show the previous balance, any new charges to the account, and any payments/credits applied to your account during the month. Unless we have agreed to other arrangements, the balance on your statement is due within 25 days of the statement date.

Returned Checks:

There is a $10 fee, subject to change, for any checks or automatic payments returned by the bank.

Past Due Accounts:

If your account becomes past due, we will take necessary steps to collect this debt. This may include referring your account to a collection agency, If we have to refer your account to a collection agency, you agree to pay all collection costs incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees incurred plus all court costs. In case of suit, you agree the venue shall be in Washington County, Maryland.

Patient's Name: _____

Responsible Party (if not the patient): _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION (PHI) MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: March 1, 2015

OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that health information about you is personal and are committed to protecting your health information. We create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or received by us.

We are required by law to:

- Make sure that health information that identifies you is kept private and will be used or disclosed only as described by this Notice or applicable law
- Make this Notice available to you
- Follow the terms of the Notice currently in effect

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION (PHI)

A. Treatment: We use your health information to provide you dental treatment and services. We disclose your PHI to physician(s), specialist(s), or other healthcare providers, as necessary, involved in your treatment.

B. Payment: We will use and disclose your PHI so that the services and care we provide can be billed to and payment collected from you, your insurance company, or a third party.

C. Healthcare Operations: We may use and disclose your PHI for our office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. Healthcare operations may include quality assessment and improvement activities, reviewing the competence or qualifications of our staff, evaluating staff performance, conducting training programs, accreditation, certification, and licensing or credentialing activities.

D. Treatment Alternatives: We may use and disclose your health information to tell you about or recommend treatment options or alternatives that may be of interest to you.

E. Reminders: We will use your personal information but NOT your health information to contact you in an effort to provide appointment reminders (voicemail, text, or email messages, postcards, messages left with another person).

F. Persons Involved in Care: We may use or disclose your PHI to notify a family member, your personal representative, or any other person responsible for your care of your location, general condition, or death. If you are present, then we will give you the opportunity to object to such disclosures. We will also use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays, referrals, records, and make/obtain appointment information.

G. Required by Law: We will use or disclose your PHI when we are required to do so by law. We may also disclose to military authorities the health information of Armed Forces personnel. We may disclose to authorized federal officials health information required for lawful intelligence, national security activities, and counterintelligence.

H. Abuse or Neglect: We may disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of others.

I. Marketing: We will NOT use or sell your PHI for mass marketing communications or any other reason.

J. Your Family and Friends: We must disclose your PHI to you, as described in the Patient Rights section of this notice. We may also disclose your health information to family members, friends, or other persons to the extent necessary to help with your care or with payment for your care.

YOUR PATIENT RIGHTS

A. Right to Inspect and Copy: You have the right to inspect and copy PHI. **Requests for copies of your health information must be made in writing and must include your preferred format- digital or paper.** We may charge a fee to cover the costs of copying, mailing, supplies, or other expenses incurred by your request.

B. Right to Amend: You have the right to request that we amend your PHI. Your request must be in writing and must explain why the information should be amended. We reserve the right to deny the request.

C. Right to Request Restriction: You have the right to request, in writing, that we place additional restrictions on our use or disclosures of your PHI. We are not required to agree to these additional restrictions, but if we do agree, we must abide by our agreement.

D. Right to Notified of a Breach: You have the right to be notified if we discover a breach in unsecured protected PHI.

D. Right to Confidential Communication: Your have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. Your request must be in writing and must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location requested. Contact our Privacy Officer if you require such confidential communications.

E. Right to an Accounting of Disclosers: You have the right to request an “accounting of disclosures”- a list of the disclosures of your PHI, with exceptions. We do not need to account for disclosure made: (1) to you; (2) pursuant to your written authorization; (3) for the purpose of carrying out treatment, payment, or operations; (4) to persons involved in your care, or to notify your family about your whereabouts; (5) incidental to another permissible use or disclosure; (6) for national security or intelligence purposes; (7) to a health oversight agency or law enforcement official if they so request. The accounting will include the date of each disclosure, the name of the entity or person to whom the disclosure was made, and a brief description of the information disclosed. You must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six (6) years and may not include dates before April 14, 2003.

QUESTIONS AND COMPLAINTS

If you feel your privacy has been violated, you may file a complaint:

Susan Williams, Privacy Officer
South Mountain Dental, LLC
708 Chase Six Blvd
Boonsboro, MD 21713
(301) 432-4322
susan@southmtndental.com

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the U.S. Department of Health and Human Services.
You will not be penalized for filing a complaint.

SOUTH MOUNTAIN
DENTAL

ACKNOWLEDGMENT of RECEIPT of *NOTICE of PRIVACY PRACTICES*

You may refuse to sign this form

I have received or been offered a copy of this office's *Notice of Privacy Practices.*

_____
Signature

_____
Patient's Name

_____
Date

OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our *Notice of Privacy Practices*, but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (be specific)

_____

_____

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