

Dan Eisenberg, D.D.S.

18111 Prince Philip Dr., Suite T-17
- Olney, MD 20832
(301)-774-7887

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PURPOSE OF CONSENT

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. This notice is posted through binder format in the reception area. A written copy in English is available. You have the right to receive this notice upon request.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Date _____
Signature of person completing form

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Relationship to Patient: _____

Child's Name: _____

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of your protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Date _____
Signature of person completing form

Dan Eisenberg, DDS
Policy Of Payment For Dental Services

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

As a courtesy to you, we will fill your insurance claims. You must realize that all charges are your responsibility from the date the services are rendered. Due to the ever changing health insurance laws and regulations, we cannot guarantee that services rendered are covered by your insurance policy. In the event that your insurance does not cover our services, you will be responsible for payment. We accept cash, checks, Visa and Mastercard. We can also assist you with applying for Care Credit Financing.

At your initial visit, you must disclose all information regarding insurance coverage that you plan to use at this office. You are also responsible for informing us of any changes to your insurance coverage. We do not work with certain insurance companies/plans. If, after treatment is initiated and any secondary policy is brought to our attention, you may have voided your right to utilize that insurance per our "no-use insurance agreement."

Charges not paid within 60 days by your insurance company will be made "patient responsibility." In the event of non-payment, you will be responsible for the cost of collections, court costs and any reasonable legal fees should these be required. Returned checks will result in a \$25.00 penalty. **Account balances over 30 days past due will start to accumulate inters charges of 24% APR. This applies to all overdue account balances.**

We reserve the right to charge for appointments broken or cancelled without **48 hours** notice at a rate of **\$25-50 per half hour**.

Any procedures started, such as crowns, bridges, dentures and root canals require the patient to return to finish treatment in a timely manner (6 weeks). If the patient fails to return to finish treatment within this time period and if the tooth fails or appliance does not fit, **no refund will be given up**. Patient will be responsible for any insurance company refunds and a remake charge may be assessed.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. **We are here to help you**. Please sign below to indicate that you have read and understand our policy of payment for dental services.

Printed patient/Guardian name

Signature

Date

Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____
Name _____ Home Phone _____
Last Name First Name Initial
Address _____ Cell Phone _____
City _____ State _____ Zip _____ E-mail _____
Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured Employed By _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____

Date of Last X-Rays _____

City, State _____

How Often Do You Floss? _____

Date of Last Dental Visit _____

How Often Do You Brush? _____

Please check all that apply:

- | | | |
|--|---|---|
| Bad Breath <input type="checkbox"/> | Loose Teeth or Broken Fillings <input type="checkbox"/> | Sensitivity to Sweets <input type="checkbox"/> |
| Bleeding Gums <input type="checkbox"/> | Orthodontic Treatment <input type="checkbox"/> | Sensitivity When Biting <input type="checkbox"/> |
| Blisters on Lips or Mouth <input type="checkbox"/> | Pain Around Ear <input type="checkbox"/> | Frequent Headaches <input type="checkbox"/> |
| Finger Nail Biting <input type="checkbox"/> | Periodontal Treatment <input type="checkbox"/> | Jaw, Head or Neck Injuries <input type="checkbox"/> |
| Grinding Teeth <input type="checkbox"/> | Sensitivity to Cold <input type="checkbox"/> | Jaw Difficulty: Clicking and/or Pain.. <input type="checkbox"/> |
| Lip or Cheek Biting <input type="checkbox"/> | Sensitivity to Heat <input type="checkbox"/> | Tooth Pain <input type="checkbox"/> |

Medical History

Physician's Name _____ Date of Last Visit _____

1. Are you currently under medical treatment? Yes No

2. Have you ever had any serious illnesses or operations? Yes No

3. Are you currently taking any medication? Yes No

Please describe: _____

4. Do you smoke? Yes No

5. Do you use alcohol, cocaine or other drugs? Yes No

6. Do you wear contact lenses? Yes No

Please check all that apply:

- | | | |
|---|--|--|
| AIDS <input type="checkbox"/> | Emphysema <input type="checkbox"/> | Pacemaker..... <input type="checkbox"/> |
| Anemia..... <input type="checkbox"/> | Epilepsy <input type="checkbox"/> | Psychiatric Care <input type="checkbox"/> |
| Arthritis, Rheumatism <input type="checkbox"/> | Fainting or Dizziness <input type="checkbox"/> | Radiation Treatment..... <input type="checkbox"/> |
| Artificial Heart Valves <input type="checkbox"/> | Glaucoma <input type="checkbox"/> | Respiratory Disease..... <input type="checkbox"/> |
| Artificial Joints <input type="checkbox"/> | Headaches..... <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Heart Murmur <input type="checkbox"/> | Scarlet Fever <input type="checkbox"/> |
| Back Problems <input type="checkbox"/> | Heart Problems..... <input type="checkbox"/> | Shortness of Breath <input type="checkbox"/> |
| Bleeding abnormally, with extractions or surgery <input type="checkbox"/> | Hepatitis-Type _____ <input type="checkbox"/> | Sinus Trouble..... <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | Herpes..... <input type="checkbox"/> | Skin Rash <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Chemical Dependency <input type="checkbox"/> | HIV Positive <input type="checkbox"/> | Swelling of Feet/Ankles..... <input type="checkbox"/> |
| Chemotherapy <input type="checkbox"/> | Jaundice <input type="checkbox"/> | Swollen Neck Glands..... <input type="checkbox"/> |
| Chronic Fatigue Syndrome <input type="checkbox"/> | Jaw Pain <input type="checkbox"/> | Thyroid Problems..... <input type="checkbox"/> |
| Circulatory Problems <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Tonsillitis <input type="checkbox"/> |
| Congenital Heart Lesions..... <input type="checkbox"/> | Latex Sensitivity <input type="checkbox"/> | Tuberculosis..... <input type="checkbox"/> |
| Cortisone Treatments <input type="checkbox"/> | Liver Disease..... <input type="checkbox"/> | Tumor or growth on head/neck..... <input type="checkbox"/> |
| Cough - persistent or bloody.... <input type="checkbox"/> | Low Blood Pressure <input type="checkbox"/> | Ulcer..... <input type="checkbox"/> |
| Diabetes..... <input type="checkbox"/> | Mitral Valve Prolapse..... <input type="checkbox"/> | Venereal Disease <input type="checkbox"/> |
| | Nervous Problems..... <input type="checkbox"/> | |

7. Have you had any allergic reactions to the following:

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| Local Anesthetics (eg. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates (sleeping pills) | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

8. (Women Only) Are You:

- | | | |
|-----------------------------------|--------------------------|--------------------------|
| | Yes | No |
| Pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____