NEW PATIENT HEALTH AND REGISTRATION FORM

Patient Name: Last: ________________ First: ___________Middle: ___Title:____ Nick Name:___________
Home Address: ____
City: ____________________________________ State: ____________________Zip Code ______________
Sex M F Date of Birth : ________________Social Security Number:_________________________
Marital Status: ___________ Email : ____
Home Phone: _________________ Cell Phone: _________________ Work Phone: _________________
Employer: _____________________________ Occupation: ______________________________________
Whom may we thank for referring you to our Practice? ____

DENTAL BENEFIT INFORMATION

Dental Benefit Company:_____________________ Subscriber's Name : ____________________________
Subscriber's Social Security Number: ________________ Date of Birth: _________Phone: ____________
Group# _________________Subscriber's Employer: ____

IF YOU HAVE TWO DENTAL BENEFITS PLEASE FILL OUT THE NEXT FEW LINES

Secondary Dental Benefit Company:____________________ Subscriber's Name _____________________
Subscriber's Social Security Number: _____________________ Date of Birth: _______________________
Group # _________________Subscriber's Employer: ____

EMERGENCY CONTACT

Name: ____________________________ Relationship: _____________________ Phone: ______________

DENTAL HEALTH HISTORY INFORMATION

It is important that we know your medical and dental history. These facts have a direct bearing on your dental health. Thank you for taking the time to Completely fill out this Medical Form.

Reason for today's visit ____
How long has it been since you have last seen a Dentist ________Last Dental Cleaning & Exam ________
Last Full Set Of Xrays (or) Panorex ? ____Name of Previous Dentist _____________________________
City:_ __________________________ State: __________ Phone Number: _________________
How would you rate your Present Dental Health? _________ Poor Fair Good Excellent

Do you wear Dentures? Yes No ____________ Are you Unhappy with them ?___ YES NO

Would you like to know about Permanent Replacements ___________________________ YES NO

Are you APPREHENSIVE about Dental Treatment _______________________________ YES NO

Have you ever had any Periodontal Treatment __________________________________ YES NO

Do your Gums Bleed or feel tender or Irritated __________________________________ YES NO

Are you aware of Grinding or Clenching your teeth _______________________________ YES NO

Do you frequently have Ear Aches or Neck Pain __________________________________ YES NO

Have you ever worn Braces YES NO ________________ If yes how long ago? _____________

Do you get Constant Bad Breath, or a Bitter or Sour Taste ______________________ YES NO

Do you Floss? YES NO _________________________________ If yes how often_____________

Would you like your smile to Look Better or Different? ___________________________ YES NO

Would you like Information on Teeth Whitening? _________________________________ YES NO

OVER---------------------->

MEDICAL INFORMATION

Are you presently under a Physician's care? ____ YES NO

If yes please list Conditions ____

Have you ever had Botox or Derma Fillers? ____

Family Physician : ______________________________ Number: ____________________

List all Medications that you are presently taking (including Birth Control,Vitamins or over the counter meds)

____

Are you (or might you be) pregnant YES NO

Do you smoke? YES NO

Do you Presently have (or) have ever been Diagnosed with any of the following conditions (please circle all that apply)

Abnormal Bleeding
Alcohol Abuse
Allergies /Hives
Anemia
Angina Pectoris
Arthritis
Artificial Bones/Joints
Artificial Heart Valve
Asthma
Cancer /Chemotherapy
Colitis

Congenital Heart Lesion
Cosmetic Surgery
Diabetes
Difficulty Breathing
Drug Abuse
Emphysema
Epilepsy /Seizures
Fainting Spells
Fever Blisters
Glaucoma
Hay Fever

Heart Disease/Attack
Heart Murmur
Hemophilia
Hepatitis A,B, C
High Blood Pressure
HIV /AIDS Tested
Kidney Disease
Leukemia
Low Blood Pressure
Mitral Valve Prolapse
Nervousness

Pace maker
Pain in Jaw /Joints
Psychiatric Treatment
Rheumatic Fever
Shingles
Sickle Cell Disease
Sinus Conditions
Stroke
Thyroid Problems
Ulcers
Venereal Disease

Please list below any other Medical/ Dental Conditions that you may have

____

____

Are you allergic to (or) have had any Adverse Reactions to any of the following Medications (Please circle all that apply)

Aspirin Codeine Erythromycin Nitrous Oxide Penicillin Sulfa General Anesthesia

Are you aware of being allergic to any medications that are not listed above?
YES NO (if yes please list below)

____

____

Patient Signature: ______________________________ Date: __________

____

WASHINGTON CENTER
for Cosmetic Dentistry

Drs.Pollowitz & Brown 4910 Massachusetts Ave. Suite 204 Washington , D.C. 20016 P: 202-244-4477 F:202-244-3273

PATIENT DENTAL SURVEY

We are striving to be the best! And we value your opinion and ask that you complete this questionnaire to help us achieve our goal.

Please be as detailed as possible.

1) Can you give us some information about your past Dental experiences?

____

____

2) How would you describe the Perfect Dentist?

____

____

3) What would you most want to achieve from your dental care?

____

____

4) What would be the most convenient days/hours for you to have your dental visit?

____

____

Name: ______________________________

Date: ______________

WELCOME

Dr. Michael R. Pollowitz & Dr. Sharon F. Brown.

are committed to providing you with superior

Cosmetic, General & Preventive Dental Care

WASHINGTON CENTER
for Cosmetic Dentistry

INSURANCE / FINANCIAL POLICY

Our office is an Out of Network provider to all dental insurance companies. As a courtesy we will gladly submit your claim to your dental insurance company, we will need you to provide us with the proper information in order for us to do this. You will be expected to pay your estimated portion when services are rendered. If you are unable to provide us with the proper information to submit your claim, you will be financially responsible for your dental work at the time of your visit.

Please remember you are fully responsible for all fees charged by our office regardless of any insurance benefits including any balance remaining after insurance benefits and or co-pays. Our office will bill you directly for any claims left unpaid by your dental insurance after 60 days.

Name (Print) I ________________________________ have read and acknowledged this policy

By signing below, I agree to these terms

Signature: ____ Date: ______________________

For your convenience we accept Cash, Checks, & all Major Credit Cards.
If you have any questions or concerns, please give our office a call at 202-363-2500. Many times a simple phone call can clear any misunderstanding you may have.

OFFICE CANCELLATION POLICY

Please Help us Help you

Your appointed time has been reserved exclusively for you and a no show or short notice cancellation affects you, us, and other patients that would have wanted that appointment.

Our office has a 36 hour (business day) cancellation policy. A fee is charged for all short notice cancellations (or) no shows. Hygiene appointment fee is $50.00 and a Doctor appointment is $150.00 for each scheduled hour that was reserved. Though your appointment date & time is your responsibility as a courtesy we do our best to try and remind you, with emails, texts, and phone calls. If an appointment needs to be rescheduled please be kind enough to give us proper advance notice.

Name: (Print) I ______________________________ have read and acknowledged this policy.

By signing below, I agree to these terms.

Signature: ________________________________ Date: _____________________

Revised May 2013

RECORDS RELEASE FORM

WASHINGTON CENTER
for Cosmetic Dentistry

To: Dr.____

Phone#: (____) ______-__________Fax# (___) _______-________

Please forward all of my **records** and **x-rays** to Washington Center for Cosmetic Dentistry. Please contact me if you have any questions at (______) _______________

Patient Name: ____________________________ DOB: _______________

Signature: ________________________________ Date: ________________

From: The Office of Drs. Pollowitz & Brown
4910 Massachusetts Ave. NW Suite 204
Washington, DC 20016
Email: wccd@amazingdentistry.com
P 202-244-4477
F 202-244-3273

Confidentially Notice: This message is intended only for the individual or entity addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader is not the intended recipient for delivering the message solely to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone at (202) 363-2500 and destroy this document. Thank you.

Notice of Privacy Practices for Protected Health Information

<u>This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!</u>

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

<u>Your Health Information Rights</u>
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will <u>not</u> include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our administrator, in person or in writing, during normal hours. S[he] will provide you with assistance on the steps to take to exercise your rights.

<u>Our Responsibilities</u>
The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office administrator.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our office administrator. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is **200 Independency Ave. S.W. Washington, D.C., 20201, phone # 1-877-696-6775, http://HHS.gov**

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website

If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: *04/1/2003*

I, ____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

____ ________________________________

Name Date