VANIK

DENTAL GROUP OF ANNAPOLIS

Family & General Dentistry

Welcome!

Thank you for choosing our team! We will strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help!

PATIENT

Name:_____
Nickname:_____
Address: _____
_____
DOB: ___/___/___ □ Female □ Male
SSN:_____
Home #:_____
Cell#_____
Work#_____
Email address:_____
Person to contact in case of emergency:
_____
Emergency contact #_____

PERSON RESPONSIBLE FOR ACCOUNT

□ Self □ Spouse □ Parent □ Guardian
Name: _____
Address: _____
_____
DOB: ___/___/___ □ Female □ Male
SSN:_____
Home #:_____
Cell#_____
Work#_____
Occupation: _____

Whom may we thank for referring you?

_____

INSURANCE

We accept many types of dental insurance, with the exception of HMO/DHMO plans. We are participating providers with many PPO plans. If we do not participate in your network, we can still provide you with dental care, and will help you maximize your dental benefits. If you have additional questions, we are happy to answer them.

PRIMARY DENTAL INSURANCE

Policy Holder: _____
DOB: _____
Employer: _____
Member ID: _____
Group #:_____
Relationship to patient: _____

SECONDARY DENTAL INSURANCE

Policy Holder: _____
DOB: _____
Employer: _____
Member ID: _____
Group #:_____
Relationship to patient: _____

1610 McGuckian Street Annapolis, MD, 21401
(410) 268-5046 Fax (410) 263-2179

VANIK

DENTAL GROUP OF ANNAPOLIS

Family & General Dentistry

Preferred Methods of Communication

I wish to be contacted in the following manner (check all that apply)

Home

□ OK to leave messages on home telephone: _____with detailed information.
□ OK to leave messages on cell phone: _____with detailed information.
□ Leave message with call-back number only.

Work

□ OK to leave messages on work phone: _____with detailed information.
□ Leave message with call-back number only.

Written Communication

□ OK to mail my home address.
□ OK to mail my work/office address.
□ OK to fax to this number: _____
□ OK to email to this address: _____

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling 410-268-5046

_____ _____
Signature Please print name

_____ _____
Date Date of birth

1610 McGuckian Street Annapolis, MD, 21401
(410) 268-5046 Fax (410) 263-2179

VANIK

DENTAL GROUP OF ANNAPOLIS

Family & General Dentistry

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

The dental chart is property of the dentist. Dentists are obligated, upon request of the patients or his/her legal representative, to furnish COPIES of all records made of the examination or treatment, including x-rays.

The release of copies of dental records may not be conditioned upon payment of unpaid fees for services rendered. A patient's record cannot be withheld if there is an outstanding balance. The dentist may charge a fee for copying the records.

Payment of copying fees may be required upon delivery of the copies. State law recommends supplying the records within 5 working days after receipt of the request.

Source of the record: _____
Previous Dentist Name

_____
Mailing address

_____
Telephone, Fax Number, and Email Address

Portions of the record to be released: **Any Imaging/ X-Rays and copy of dental history**

Records to be released to: Vanik Dental Group of Annapolis PA
1610 McGuckian Street
Annapolis, MD 21401
(410) 268-5046 (phone)

****Please email X-rays and dental history to: nvanikdds@gmail.com ****

****Please be sure to include the doctor's name and the date the x-rays were taken****

I hereby request and authorize release of my dental x-rays and history without limitations

_____
Patient Name

_____
Patient Signature

1610 McGuckian Street Annapolis, MD, 21401
(410) 268-5046 Fax (410) 263-2179

VANIK
DENTAL GROUP OF ANNAPOLIS

MEDICAL & MEDICATION HISTORY

NAME: **D.O.B.:** **DATE:**

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please Circle Your Answers to the following:

Are you under a Physician's care now? **YES or NO**
If YES:

Have you ever been hospitalized or had a major operation? **YES or NO**
If YES:

Have you ever had a serious head or neck injury? **YES or NO**
If YES:

Are you taking any medications, pills, or drugs? **YES or NO**
If YES:

Do you take, or have you taken, Phen-Fen or Redux? **YES or NO**
If YES:

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? **YES or NO**
If YES:

Are you on a special diet? **YES or NO**

Do you use tobacco? **YES or NO**

Do you use controlled substances? **YES or NO**

For Women ONLY: Are you…
Pregnant or Trying to get pregnant? **YES or NO**
Nursing? **YES or NO**
Taking Oral Contraceptives? **YES or NO**

Are you allergic to any of the following? (Please Circle)

Aspirin:	**YES or NO**	Penicillin:	**YES or NO**	Codeine:	**YES or NO**
Metal:	**YES or NO**	Latex:	**YES or NO**	Sulfa Drugs:	**YES or NO**
Local Anesthetics:	**YES or NO**	OTHER:			

MEDICAL & MEDICATION HISTORY (Continued)

Do you have, or have you had, any of the following? (Please circle your answer)

AIDS/HIV Positive:	**YES or NO**	Hemophilia:	**YES or NO**
Alzheimer's Disease:	**YES or NO**	Hepatitis A:	**YES or NO**
Anemia:	**YES or NO**	Hepatitis B or C:	**YES or NO**
Angina:	**YES or NO**	Herpes:	**YES or NO**
Arthritis/Gout:	**YES or NO**	High Blood Pressure:	**YES or NO**
Artificial Heart Valve:	**YES or NO**	High Cholesterol:	**YES or NO**
Artificial Joint:	**YES or NO**	Hives or Rash:	**YES or NO**
Asthma:	**YES or NO**	Hypoglycemia:	**YES or NO**
Blood Disease:	**YES or NO**	Irregular Heartbeat:	**YES or NO**
Blood Transfusion:	**YES or NO**	Kidney Problems:	**YES or NO**
Breathing Problems:	**YES or NO**	Leukemia:	**YES or NO**
Bruise Easily:	**YES or NO**	Liver Disease:	**YES or NO**
Cancer:	**YES or NO**	Low Blood Pressure:	**YES or NO**
Chemotherapy:	**YES or NO**	Lung Disease:	**YES or NO**
Chest Pains:	**YES or NO**	Mitral Valve Prolapse:	**YES or NO**
Cold Sores/Fever Blisters:	**YES or NO**	Osteoporosis:	**YES or NO**
		Pain in Jaw Joints:	**YES or NO**
Congenital Heart Disorder:	**YES or NO**	Parathyroid Disease:	**YES or NO**
		Psychiatric Care:	**YES or NO**
Convulsions:	**YES or NO**	Radiation Treatment:	**YES or NO**
Cortisone Medicine:	**YES or NO**	Recent Weight Loss:	**YES or NO**
Diabetes:	**YES or NO**	Renal Dialysis:	**YES or NO**
Drug Addiction:	**YES or NO**	Rheumatic Fever:	**YES or NO**
Easily Winded:	**YES or NO**	Rheumatism:	**YES or NO**
Emphysema:	**YES or NO**	Scarlet Fever:	**YES or NO**
Epilipsy or Seizures:	**YES or NO**	Shingles:	**YES or NO**
Excessive Bleeding:	**YES or NO**	Sickle Cell Disease:	**YES or NO**
Excessive Thirst:	**YES or NO**	Sinus Trouble:	**YES or NO**
Fainting Spells/ Dizziness:	**YES or NO**	Spina Bifida:	**YES or NO**
		Stomach/Intestional Disease:	**YES or NO**
Frequent Cough:	**YES or NO**		
Frequent Diarrhea:	**YES or NO**	Stroke:	**YES or NO**
Frequent Headaches:	**YES or NO**	Swelling of Limbs:	**YES or NO**
Genital Herpes:	**YES or NO**	Thyroid Disease:	**YES or NO**
Glaucoma:	**YES or NO**	Tonsillitis:	**YES or NO**
Hay Fever:	**YES or NO**	Tuberculosis:	**YES or NO**
Heart Attack/Failure:	**YES or NO**	Tumors or Growths:	**YES or NO**
Heart Murmur:	**YES or NO**	Ulcers:	**YES or NO**
Heart Pacemaker:	**YES or NO**	Venereal Disease:	**YES or NO**
Heart Trouble/Disease:	**YES or NO**	Yellow Jaundice:	**YES or NO**

Have you ever had any serious illness not listed above? **YES or NO**

If YES: _____

Additional Comments:

VANIK
DENTAL GROUP OF ANNAPOLIS

HIPAA DISCLOSURE

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 23, 2013 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law enforcement. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

VANIK
DENTAL GROUP OF ANNAPOLIS

HIPAA DISCLOSURE

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OR PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law.) You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, expect to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use of disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communications. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web sute or by electronic mail (email).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if 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.

1610 McGuckian Street Annapolis, MD, 21401
(410) 268-5046 Fax (410) 263-2179

VANIK

DENTAL GROUP OF ANNAPOLIS

Family & General Dentistry

I have received a copy of this office's Notice of HIPAA Privacy Practices.

Patient's name (Please Print):_____

Patient's Signature:_____

Relationship to patient: □ self □ guardian/parent

Date: _____

For Office Use Only

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

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please specify):

_____

_____

_____

1610 McGuckian Street Annapolis, MD, 21401

VANIK

DENTAL GROUP OF ANNAPOLIS

Family & General Dentistry

Welcome! We are grateful you chose us to help you care for your dental health! Our goal is to provide you and your family with optimal dental care at every age. We endeavor to make you feel welcome and as comfortable as possible at every appointment in our office. We encourage you to ask questions and desire to provide you with thorough information to make the best decisions in your treatment. This includes understanding your choice in treatment plan as well as our financial policy.

FINANCIAL AGREEMENT:

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Thanks to a state of the art computer system, these estimates are quite reliable, but there are times when an insurance company "downgrades" or even excludes a necessary procedure to a less expensive option and passes the extra cost to the patient. In this event, a statement is mailed with an expected payment of the balance upon receipt. Payments may be made using cash, check, Visa, Mastercard, and American Express. We also partner with CARECREDIT, another financing option available only for healthcare expenses. Talk with the office staff about applying for credit before your appointment. Approval or denial is determined immediately, and upon approval your card is available for use in treatment that day.

APPOINTMENTS CANCELLATION & RESCHEDULING POLICY:

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel/reschedule at the last minute. Therefore, we do require a **24 hour notice, prior to your scheduled appointment time,** for any cancellations or appointments that need to be rescheduled. Fail to do so will result in a **$50 late fee** being assessed to your account. We appreciate your timely consideration, as we do maintain a list of patients waiting for 'sooner if possible appointments' and your timely cancellation/rescheduling may help serve that person in need!

INSURANCE INFORMATION:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will strive to help you receive your maximum allowable benefits. In order to do this we need your insurance card and/or policy with you when you come for your appointment.

We will diagnose treatment based on your dental health, not your insurance coverage.

1610 McGuckian Street Annapolis, MD, 21401
(410) 268-5046 Fax (410) 263-2179

VANIK

DENTAL GROUP OF ANNAPOLIS

Family & General Dentistry

You must realize that: Dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a dentist may recommend a crown for a tooth that has extensive decay; however, the dental plan may only cover the cost of a filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling. We strive to avoid financial surprises like this for you with pre-authorizations through your insurance company, but again, we diagnose and offer treatment based on your needs, not your insurance coverage. Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of this practice.

Patient's Signature:

_____

Patient's name (please print):

_____

1610 McGuckian Street Annapolis, MD, 21401
(410) 268-5046 Fax (410) 263-2179