UTTER Dental Care

your smile is our passion

23401 Frederick Road • Clarksburg MD 20871
(240) 261-4368

Patient Registration

First Name: _____

Middle Name (Optional): _____

Last Name: _____

Preferred Name/Nickname: _____

Birth Date (MM/DD/YY): _____

Social Security Number: _____

Sex/Gender: _____

Marital Status: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Cell Phone: _____

Home Phone: _____

Email Address: _____

EMERGENCY CONTACT: please let us know who to contact in case of emergency

1) Name: _____ Phone Number: _____ Relationship: _____

2) Name: _____ Phone Number: _____ Relationship: _____

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Medical History

First Name:_____ **Last Name:**_____

1. Have you been under the care of a physician during the past 2 years? Yes or No
If yes, for what?
Physician's Name: _____
2. Have you taken any medication or drugs during the past 2 years? Yes or No
3. Are you taking any medication, drugs or pills now? Yes or No
If yes, what? _____
4. Any history of bisphosphonate use? Yes or No
Date of use: _____ Type: _____
5. Are you aware of having an allergic (or adverse) reaction to any medication, or substance such as antibiotics or anesthesia? Yes or No
If yes, please explain:_____
6. Have you been a patient in the hospital during the past 5 years? Yes or No
7. Have you lost or gained more than 10 pounds in the past years? Yes or No
8. **WOMEN**: Are you pregnant? Yes or No
How many weeks? _____
Nursing? Yes or No
Taking Birth Control? Yes or No

Please indicate which of the following. Check Yes or No to each item you have had, or have at present conditions:

Yes	*No*		*Yes*	*No*	
☐	☐	Pre-Medication/ Antibiotic (before apt)	☐	☐	High Blood Pressure
☐	☐	Heart (Surgery, Disease, Attack)	☐	☐	Heart Murmur
☐	☐	Chest Pain	☐	☐	Mitral Valve Prolapse
☐	☐	Cortisone Medicine	☐	☐	Ulcers
☐	☐	Swollen Ankles	☐	☐	Diabetes
☐	☐	Stroke	☐	☐	Thyroid Problems
☐	☐	Diet/ Special Restricted	☐	☐	Glaucoma
☐	☐	Artificial Joints	☐	☐	Emphysema
☐	☐	Kidney Problems	☐	☐	Chronic Cough
☐	☐	Ear/ Sinus Infection	☐	☐	Tuberculosis

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Yes	No		Yes	No	
☐	☐	Hepatitis A	☐	☐	Asthma
☐	☐	Hepatitis B	☐	☐	Hay Fever
☐	☐	Cold Sores/ Fever Blisters	☐	☐	Radiation Therapy
☐	☐	Liver Disease	☐	☐	Chemotherapy
☐	☐	Yellow Jaundice	☐	☐	Tumors, Malignancies
☐	☐	Sickle Cell Disease	☐	☐	Anemia
☐	☐	Neurological Disorder	☐	☐	Venereal Disease
☐	☐	Scarlet Fever	☐	☐	AIDS
☐	☐	Hemophilia	☐	☐	Nervous/ Anxious
☐	☐	Bruises Easily	☐	☐	Psychiatric Problems

9. Do you have any disease, condition or problem not listed? Yes ☐ No ☐

If yes, please list: _____

Allergies:

Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Jewelry
☐	☐	Dental Anesthetics	☐	☐	Metals
☐	☐	Erythromycin	☐	☐	Penicillin
☐	☐	Tetracycline			

All information is complete and accurate to the best of my knowledge.

Patient signature: _____

Parent/ Guardian signature: _____ **Date:** _____

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Dental History

1. What is the reason for your visit today? _____
2. Date of last Dental Cleaning: _____
3. What was done at your last dental visit? _____
4. Previous Dentist's Name: _____ Phone #: _____
5. How often do you have dental exams/cleanings? _____
6. How often do you brush your teeth? _____ How often do you floss? _____
7. Do you feel nervous about having dental treatment? Yes or No
8. Have you ever had an upsetting dental experience? Yes or No
   If yes, please explain: _____
9. Are you satisfied with your teeth's appearance? Yes or No
   If no, what about your mouth, teeth or existing dental work that you are unhappy with?
   _____
10. Have you been satisfied with your previous dental treatment? Yes or No
    If not, why? _____
11. Have you had a serious injury to the mouth or head? Yes or No
    If yes, please describe: _____
12. **Do you wear complete or partial dentures?** Yes or No
    - Are you happy with your dentures? Yes or No
    - Would you like to know about permanent replacements? Yes or No

ARE YOUR TEETH SENSITIVE TO:

HOT?	Yes or No
COLD?	Yes or No
SWEETS?	Yes or No
BITING OR CHEWING?	Yes or No

HAVE YOU NOTICED:

MOUTH ODOR?	Yes or No
BAD TASTES?	Yes or No
Loose teeth or changes in your bite?	Yes or No

If yes, where? _____

HAVE YOU EVER HAD:

Orthodontic treatment?	Yes or No
Oral surgery?	Yes or No
Periodontal treatment?	Yes or No
An occlusal / night guard	Yes or No
T.M.J treatment?	Yes or No

DO YOU FREQUENTLY EXPERIENCE:

Cold sores, fever blisters or oral lesions?	Yes or No
Bleeding or painful gums?	Yes or No
Clicking or popping of the jaw?	Yes or No
Limited mouth opening?	Yes or No
Pain in the jaw, ear or side of face?	Yes or No

DO YOU HAVE A HISTORY OF?

Clenching or grinding your teeth while asleep or awake?	Yes or No	
Biting your lips or cheeks regularly?	Yes or No	
Holding foreign objects with your teeth (pencils, pipe)?	Yes or No	
Biting fingernails?	Yes or No	
Mouth breathing while asleep or awake?	Yes or No	
Smoke or chew tobacco?	Yes or No	If Yes, how much? _____
Do you drink more than one alcoholic beverage per day?	Yes or No	If Yes, how much? _____

All information is complete and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ **Date:** _____

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OFFICE AND FINANCIAL AGREEMENT

PATIENT RECORDS: We are required to retain all original patient records. I understand that I can request copies of my dental records and radiographs at any time by submitting a written request. When patient photographs are taken, I hereby authorize their use. I authorize your office to maintain my signature on file for insurance purposes.

REGARDING PAYMENT: We desire to make dental treatment affordable to all of our patients; therefore, we offer the following payment options:

1. Visa, Mastercard, American Express, Discover, cash and check.
2. We also offer flexible payment plans of up to 6 months upon approval with Care Credit. Approval must be received prior to treatment date.

Payment is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist. If there is treatment that requires fabrication by a dental laboratory, half of the patient portion will be required at the initial appointment. The remaining balance is due at the time of final delivery. Checks that are returned to our office from your financial institution are subject to a $30 return check fee. This fee covers the processing fees that are charged to our office. The parent that accompanies a minor child or minor children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized before the appointment date or previous arrangements have been made.

PATIENTS WITH DENTAL INSURANCE: We accept assignment from most insurance companies. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services. Insurance claims cannot and will not be backdated. We understand insurance guidelines can be difficult to understand at times. Fortunately with the information provided to us by your insurance company, we are able to provide some assistance in estimating your insurance benefits. However, your insurance company makes final determination once treatment is completed and the claim is submitted. Your insurance is a contact between you and your insurance company; therefore, all charges are your responsibility. Patients are responsible for any deductibles, co-payment and non-covered service at the time service is provided. Any balance remaining unpaid after 45 days from the date of service will be due by the patient. Please consult your benefits handbook or insurance carrier for details. As a courtesy we will gladly process your insurance claim forms. All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims. I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to an interest charge of 1.5% for each month past due. I am also responsible for all collection costs incurred by the dental office.

COLLECTION POLICY: We also reserve the right to report delinquent accounts to the credit bureau. Should collection proceeding be initiated on an account, we shall be entitled to attorney's fees, collection costs and interest on the unpaid balance at an annualized rate of 18%.

APPOINTMENT CANCELLATION POLICY: Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment so we ask that you kindly give us a minimum notice of 2 business days. Appointments cancelled or broken without 24 hour notice will be subject to a $50.00 charge. If two or more appointments are broken without the appropriate notice, we reserve the right to cancel any and all future appointments.

I have read and understand the Utter Dental Care Office and Financial Agreement above. By signing this document I am agreeing to all the above.

Patient or Guardian Signature:_____ **Date:**_____

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NOTICE OF PRIVACY PRACTICES (HIPAA ACT)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required 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 privacy practices that are described in this Notice while it is in effect. This Notice takes effect of the date above**,** 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 create 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.

USE AND DISCLOSURES OF HEALTH INFORMATION & PATIENTS RIGHTS: 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 provided to you. **Healthcare Options:** 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 disclosure permitted by your authorization while it is 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 you 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 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:** When required by law, we may use or disclose your health information. **Abuse and 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). **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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time.

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You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure. **Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for a purpose, 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 the additional request. **Restriction:** You have the right to request that we place additional restrictions on our use and 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 payment will be handled under alternative means or location you request. **Amendments:** 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. 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 request 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 chose to file a complaint with us or with the U.S. Department of Health and Human Services

Contact Information:
Utter Dental Care, Tamdan Vodinh D.D.S.
23401 Frederick Road, Clarksburg, MD, 20871
240-261-4368 Fax: 240-261-4369
utterdental@gmail.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HAVE RECEIVED AND ACKNOWLEDGE THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

Patient Signature:_____ Date:_____

Parent/Guardian's Signature:_____ Relationship: _____

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 ☐Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement ☐Other: _____

Front Desk Signature: _____ Date: _____