Confident Smiles of Germantown by Dr. Dean A. Schramek
10 Executive Park Court
Germantown, MD 20874
301-540-2065

Patient Information

Patient Name: ______________________________ Date: __________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other__________

Social Security #: __________________ Birth Date: __________________

Phone(Home): __________ (Work): __________ Ext: ______ Cell Phone: __________

E-Mail Address: __________ Emergency contact person & tel.# __________________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: __________ Reason for this visit: __________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies to any materials
List: ______________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness

☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis Type A,B,or C
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease

☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date: __________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke

☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Other Drug Allergies:
____
____
____
☐ Smoking or Tobacco Chewing Habit

1. Are you currently taking any medications? ☐ Yes ☐ No If yes, please list: 1.__________
2.__________ 3.__________ 4.__________
5.__________ 6.__________ 7.__________

2. Do you need to premedicate before dental visits? ☐ Yes ☐ No

3. Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: ______________________________

4. Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain: __________
____
Name of Physician: ______________________________ Phone: __________

5. Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ Date: __________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other__________

Name of person or office referring you to our practice: ______________________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ____________ (Work): ____________ Ext:______ Best time to call: ____________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________ Occupation: ____________________

Address: ______________________________
Street City State Zip Code

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #:____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________

Insurance Plan Name and Address: ______________________________

____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #:____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________

Insurance Plan Name and Address: ______________________________

____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients Insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: ____________ Relationship to Patient: ____________
Signature of patient, parent or guardian

______________________________ Date: ____________ Relationship to Patient: ____________
Signature of guarantor of payment/responsible party

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NOTICE OF PRIVACY PRACTICES

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.

Understanding your health record

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination and test results, diagnoses, treatment, and a plan for future care are recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy, and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Understanding your health information rights

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibilities

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. Other than the reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

To receive additional information or report a problem

For further explanation of this notice you may contact Dr. Schramek at 301-540-2065. If you believe your privacy rights have been violated, you have the right to file a complaint with our medical office or with the Secretary of Health and Human Services with no fear of retaliation by this office.

Your health information will be used for treatment, payment, and health care operations.

Treatment-Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician recording his own expectations and those of others involved in providing you care. The sharing of your health information may progress to others involved in your care, such as specialty physicians or lab technicians.

Payment-Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

Health Care Operations-The medical staff in this office will use your health information to access the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

Acknowledgement of receipt of notice of privacy practices form

Patient or Guardian Signature ______________________________**Date**_________

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Cancellation/No Show Policy

We care about your time and strive to keep the flow in our office going in an efficient manner. We are reinforcing the following Cancellation/No Show policy for our office.

Our policy states:

- A $50 fee will be charged for any **Cancellation made less than 48 business hours from the appointed time.** Our regular business hours are Monday through Thursday from 8:30 A.M. to 5:00 P.M. and every second and fourth Friday of each month from 8:30 A.M. to 4:00 P.M.

- A $50 fee will be charged for any **No Show/Missed** dental appointment.

Your dental health is very important to us, and when we reserve time for you it is vital that you follow through with your dental treatment.

Thank you for your cooperation.

________________________________ __________

Patient/Guardian Signature **Date**