robinwood dental

11110 Medical Campus Road, Suite 148, Hagerstown, MD 21742 | 4310 Old National Pike, Middletown, MD 21769
robinwooddentalcenter.com 240.313.9660

PATIENT INFORMATION

_______________________________________ _______________________________ ____/_____/______ F/M
Last First Middle Initial *How Should We Address You?* Date of Birth Sex

____
Street City State Zip Code

______/_____/________ _______-_______-________ ______-_______-_______ _______-______-_______
***Required Social Security Number** Home Telephone Work Telephone Cell Telephone

____
Email

___________________________ ____
Employer Emergency Contact Name Telephone Number

FT College Student ___________________________________ Marital Status: Single Married Divorced Widowed
Name of college

MEDICAL HISTORY

___________________________________ ______-________-_________
Name of **Physician** Telephone Number

Have you ever had any serious illnesses or operations? ___yes ___no

If yes, please describe____

Have you ever had a blood transfusion? ___yes ___no

If yes, approximate date____

Women
Are you pregnant? ___yes ___no Nursing? ___yes ___no Taking Birth Control Pills? ___yes ___no

Please X if you have or have had any of the following:

- ☐ Aids/HIV Positive
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Biophosphonates
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatment
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Smoke/Tobacco Habit
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer

Do you have any disease, condition, or problem not listed? If so, please explain:

____

List any medications you are taking:

____

____

____

____

List any medications you are allergic to:

____

____

____

____

I certify that the above information is complete and accurate.

____
Patient/Guardian's Signature

_______/_______/________
Date

FINANCIAL POLICY

I understand that I am financially responsible for all charges, whether or not they are paid by insurance. I agree to pay for services rendered on the day of service. If dental insurance is involved, I agree to pay my estimated patient portion, including any deductibles that may apply.

If you are unable to pay your portion on the day of service there is a company that will provide financing for dental treatment called Care Credit. The information for the company is available on-line @carecredit.com or by phone at 800-677-0718. If you know that you will not have the necessary funds at the time of service, please call the office, 24 hours prior to your appointment, to either reschedule your appointment and/or discuss your financial issues with your business office.

If I have a payment due and choose not to pay on my account within 30 days, I agree to pay the interest charges accrued on the unpaid balance of my account up to 1.5% per month. I understand that after 90 days if I have not paid my agreed upon billing arrangements my account may be turned over to an attorney and/or collection agency. I agree to pay any and all collection fees and am aware that the collection fee could be up to 50% of the past due balance in addition to the balance already due on the account.

There are many procedures that insurance companies do not cover. Our office does only composite resin restorations only (white fillings). Most insurance companies will only pay for amalgam fillings (silver fillings) on the posterior (molar) teeth. Also, some insurance companies will have limitations on services, e.g. sealants. Please be advised that you will be responsible to pay for any non-covered services. It is your responsibility to know what your insurance covers and it's limitations.

As a courtesy Robinwood Dental will send text and email reminders of your exclusively reserved appointment time. Please confirm your appointment when you receive your reminder. Robinwood Dental reserves the right to charge a minimum of $50.00 for an appointment that is cancelled or missed without advanced notice of two business days. In order to change or cancel an appointment, you MUST speak with one of our staff members. Cancellations will not be accepted on our office voicemail. Patients arriving 10 or more minutes late for their appointment will need to be rescheduled and will incur a missed appointment charge.

I have read and understand the above statements and I agree to be responsible for my balance after insurance pays their portion.
I AGREE TO ACCEPT ALL FINANCIAL RESPONSIBILITY AS STATED ABOVE FOR DENTAL SERVICES.

_______________________________________ ______/_______/______
Signature of Financially Responsible Person Date

_______________________________________ ______/_______/______
Print Name of Financially Responsible Person Date

Continue on next page…

FINANCIAL POLICY

PLEASE COMPLETE IF FINANCIAL RESPONSIBILITY IF **ANYONE OTHER THAN THE PATIENT**

I understand that I am financially responsible for all charges, whether or not they are paid by insurance. I agree to pay for services rendered on the day of service. If dental insurance is involved, I agree to pay my estimated patient portion, including any deductibles that may apply.

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____
Patients Name

_____________________________________ ____/_____/______
Financially Responsible Persons Name Date of Birth

_____/_____/________ ____-_____-______
***Required Social Security Number** Home Telephone

____
Address-Street City State Zip Code

ROBINWOOD DENTAL CENTER

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION UNDER HIPAA

SECTION A: PATIENT INFORMATION THAT IS GIVING CONSENT (IF MINOR, adult please sign bottom of form)

Name: ____

Address: ____

Telephone: ____________________________________ E-mail: ________________________________

Social Security Number: ______________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dawn Thomas

Telephone: (240)313-9660 Fax: (240)313-9661

Address: 11110 Medical Campus Road, #148, Hagerstown, MD 21742

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

PRINT SIGNATURE

I, ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices and have received a copy for my personal records. 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 health care operations.

Signature: ____ Date: ___________________________

If this Consent is signed on behalf of the patient, complete the following:

Representative's Name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Continue on next page…

IF YOU DO NOT WANT US TO BILL, CONTACT YOUR INSURANCE COMPANY OR ANY OTHER HEALTHCARE OFFICE FILL OUT BOTTOM OF FORM.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my 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.

Signature: ____ 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)

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robinwood dental

Social Media Release Form

I consent to the use of my personal image and likeness, including but not limited to images representing and depicting the treatment provided to me and the effect thereof, by Robinwood Dental for any lawful use Robinwood Dental deems appropriate, including for treatment, advertising his/her/its services to the general public (including via social media and electronic media), illustration, and publication to the public at large for educational purposes. I hereby relinquish any and all rights to my likeness or any image of me obtained by any photographic or digital means by Robinwood Dental during the course of my treatment. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising, promotional or educational materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by Robinwood Dental. I understand and agree that I have no right to be consulted about or approve of any such alterations before my image is used.

I understand that Robinwood Dental will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand, however, that Robinwood Dental cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that Robinwood Dental may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my date of birth and/or age and my other relevant medical conditions, in describing the treatment rendered to me as depicted in any image of me.

I understand that Robinwood Dental may not and has not conditioned the rendition of treatment to me upon my authorization of the use of my image and/or likeness. I have read the foregoing in its entirety and understand its terms.

Patient Name______________________________________

Signature of Patient, Legal Guardian or Authorized Representative

____Date_________________

Relationship to Patient: ____________________________

Printed Name of Patient, Legal Guardian or Authorized Representative

____