



Elliot Einbinder, DDS
2835 Smith Avenue Suite A
Baltimore, Maryland 21209
(410) 486-3898

PATIENT HEALTH RECORD

In order to help us render the proper dental services for you, please answer the following:

Date: ____/____/____

Social Security #: _____ Date of Birth: ____/____/____

Name: _____
(First) (Middle) (Last)

Home Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Do you receive text messages? Yes No

Sex: M / F Height: _____ Weight: _____ Email: _____
Can we email you? Yes No

Occupation: _____ Employer: _____

What is your preferred contact method? _____

Single Spouse's Name: _____
 Married Occupation: _____
 Divorced Employer: _____
 Widowed Work Phone: _____
Cell Phone: _____

Whom should we thank for recommending our office? _____

Do you have dental insurance? _____ Name of Insurance: _____

Primary Subscriber: _____ Date of Birth: _____ SSN: _____

We would also like a copy of your dental insurance card for our records.

Person responsible for payment of account: _____

Address and phone number if other than patient: _____

OFFICE FINANCIAL POLICY: Our office requires payment in full at the time services are rendered, unless other arrangements are made with the office manager. Patients fully understand that they are solely responsible for all dental fees. We will assist you in submitting for any dental insurance reimbursement. We accept Cash, Check, Visa or Mastercard. Prepayment of complex cases (over \$1000) with cash or check are entitled to a 5% courtesy.

MEDICAL HEALTH HISTORY

General Health: Excellent Good Fair Poor

Name of primary care physician or internist: _____

Phone Number: _____

Name of specialist: _____

Date of last physical exam: _____

What is your blood pressure: ____/____

Please list any medications taken:

Are you allergic to: Penicillin Codeine Local Anesthetic Latex

Any other medications? _____

Have you ever been treated for:

Y N Heart Disease

Y N Rheumatic fever

Y N Abnormal Blood Pressure

Y N Ulcers

Y N Tuberculosis or Lung Disease

Y N Mental or Nervous Disorder

Y N Venereal Disease or STD

Y N Diabetes

Y N Epilepsy

Y N Anemia

Y N Congenital Heart Lesions

Y N Heart Murmur

Y N Jaundice

Y N Asthma or Hay Fever

Y N Sinus Trouble

Y N Chronic Cough

Y N Hepatitis

Y N Stroke

Y N AIDS/HIV

Y N Thyroid Problems

Y N Gastrointestinal Problems

Y N Have you had any operations in the last 5 years?

Y N Have you been treated with radiation or chemotherapy?

Y N Are you subject to prolonged bleeding?

Y N Do you have a history of drug or alcohol problems?

Y N Do you use or have you used cigarettes, cigars, pipes, or chewing tobacco?
If so, how much? _____

For how long? _____

Women:

Y N Are you pregnant?

If so, how many months? _____

Do you need to be pre-medicated for dental procedures because of a prosthetic replacement?

I.E. Hip, knee, or heart valve? _____

If yes, what antibiotic has your physician prescribed? _____

DENTAL HEALTH HISTORY

When was your last dental visit? _____
When was your last professional cleaning? _____
Name of previous dentist: _____
Are you currently under the care of a dental specialist? _____
Do you have all your teeth? _____
If not, what teeth are missing? _____
How have these teeth been replaced? _____
Do you clench or grind your teeth? If yes, when? _____
Do you have any oral habits which might affect your oral health? _____
I.E. Pipe Smoking, musical instruments, biting fingernails
Are any of your teeth sensitive to: Hot Cold Sweets Biting
Do you avoid chewing on one side of your mouth? If so, which side and why?

Oral Hygiene:

How often do you brush your teeth? _____
What texture toothbrush do you use? hard medium soft electric
How often do you floss your teeth? _____
Do your gums bleed, feel tender, or swollen? If so, what areas? _____
Reason for this visit: _____

Please add any information that you feel is important for us to know about your oral health?

I authorize Dr. Einbinder and his staff:

To perform any necessary services for diagnosis and treatment of my dental condition.

To release any information required to process insurance claims.

To release any information that permits other providers to assist in my dental healthcare.

Patient's signature: _____ Date: ____/____/____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to you use and disclosure of my protected health information to carry out payment activities in connection with claims.

Patient's signature: _____ Date: ____/____/____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the dentist or dental entity.

Patient's signature: _____ Date: ____/____/____



Elliot Einbinder, DDS
2835 Smith Avenue Suite A
Baltimore, Maryland 21209
(410) 486-3898

NOTICE OF PRIVACY PRACTICES- This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY We are required by 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 the privacy practices that are described in this Notice while it is in effect.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may 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 another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

Healthcare Operations: 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, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: is explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. 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 uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Access: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Disclosure accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, and 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 fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care.

Alternative Communication: 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 and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted.

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.

Right to Written Notice: If you receive this Notice on our website or by email, 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, 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 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.

Contact: Telephone: 410-486-3898 Fax: 410-653-9163 Address: 2835A Smith Avenue Baltimore, MD 21209

I, _____ have read this office's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For office use only:

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

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining the acknowledgment
- Other (Please specify) _____