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

Date: ____/____/____

Social Security Number: _____

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

Nickname: _____ Birthdate: ____/____/____ Age: _____ Sex: M / F

Height: _____ Weight: _____ School: _____

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

Home Phone Number: _____ Brothers/Sisters: _____

Mother's Name: _____
Occupation: _____
Employer: _____
Work Phone: _____
Cell Phone: _____
Receive text messages? ☐Yes ☐No
Email:_____

Father's Name: _____
Occupation: _____
Employer: _____
Work Phone: _____
Cell Phone: _____
Receive text messages? ☐Yes ☐No
Email:_____

Preferred contact method:_____

Legal Guardian (if other than parent): _____

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.

CONSENT FOR TREATMENT

I hereby authorize dental treatment to be performed for:

Name of child: _____ Date of Birth: _____
By Elliot Einbinder, D.D.S and his staff

Date: _____ Signature: _____
Relationship to patient: _____

MEDICAL HEALTH HISTORY
General Health: ☐ Excellent ☐Good ☐Fair ☐Poor
Name of Child's Primary Care Physician: _____
Address: _____ _____ _____ _____
(Street) (City) (State) (Zip)

Phone Number: _____
Date of last physical exam: _____

Please list any medications currently taking:

_____
_____

Is your child allergic to: ☐Penicillin ☐Codeine ☐Local Anesthetic ☐Latex
…any other allergies? _____

Does your child have or ever had any of the following?

Y N Heart Murmur
Y N Hemophilia or Prolong bleeding
Y N Sickle Cell Anemia
Y N Tuberculosis or Lung Disease
Y N Hepatitis, Jaundice, or Liver Disease
Y N Kidney Disease
Y N Asthma, Hay Fever, or Sinus Trouble
Y N Diabetes
Y N Ear Infections or other ear problems
Y N Seizures or Epilepsy
Y N Learning Disabilities
Y N Mental Retardation
Y N Psychological or Emotional Problems
Y N AIDS or HIV

Any other health problems? _____
Has your child been hospitalized in the past five years? If yes, please explain _____
_____

DENTAL HISTORY

Is this is your child's first visit to the dentist? YES NO
If no, when and where was your child's last visit? _____
Is your child having or ever had any of the following?
Y N Toothaches
Y N Abscesses
Y N Injury to mouth or teeth
Y N Bleeding gums
Y N Bad breath
Y N Discolored or stained teeth
Y N Cold sores

Does your child have or ever had habits which might affect oral health?
Y N Finger or Thumb Sucking
Y N Mouth Breathing
Y N Clenching or Grinding Teeth

Does your child have a speech problem? YES NO

Do you have well water? YES NO

Does your child use fluoride? (Circle all that apply) Toothpaste Rinse Drops Tablets

Who is responsible for tooth cleaning? Child Parent Both

How often does your child brush? Twice Daily Once Daily Occasionally Never

Are there any concerns that you would like address with the dentist? _____
_____

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.
Signature: _____ Date: ____/____/____
Relationship to Patient: _____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the dentist or dental entity.
Signature: _____ Date: ____/____/____
Relationship to Patient: _____

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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)

_____ Relationship to patient: _____
(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) _____