

PATIENT REGISTRATION FORM

Legal Name _____ Preferred Name _____

Sex: M or F Date of Birth _____ Age _____ Social Security # _____

Mailing Address _____

Daytime Phone # (in order of preference) (____)____-____ [] Home [] Work [] Cell
(____)____-____ [] Home [] Work [] Cell
(____)____-____ [] Home [] Work [] Cell

Employer Name and Address _____

Who referred you to us? _____

Who Will Be Financially Responsible For Your Account?

[] Self
[] Other – Relationship of this person to you? _____

Responsible Party's Information:

Name _____
Mailing Address _____
DOB _____ SSN _____
Daytime Phone # _____

Insurance Information (we will take a photocopy of your card):

Primary Dental Insurance:

Carrier/Name of Insurance Company _____
Name of Insurance Plan _____
Name of Planholder (if other than self) _____
SSN or ID of Planholder _____ DOB of Planholder _____
Group # _____
Patient Relation to Planholder _____
Claims Address _____

Claims Information Phone _____
Employer _____
Effective Date of Plan _____

[] If you have additional dental coverage please check this box and provide the above information for that coverage on the back of this sheet.

Assignment Of Benefits

I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO MYSELF OR THE NAMED PROVIDER FOR PROFESSIONAL SERVICES RENDERED.

SIGNED _____ DATE _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ 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: Dr. W. Russell Morgan

Telephone: 410-543-0100

Fax: 410-543-4665

Address: 106 Milford Street, Suite 304, Salisbury, MD 21804

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.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. 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 by a personal representative on behalf of the patient, complete the following:

Personal 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. 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 his 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: _____

MEDICAL HISTORY FORM

Patient's Name: _____

Occupation: _____ Birth Date: _____

If you are completing this form for another person, what is your relationship to this person?

Your Primary Care Physician _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle Yes or No, whichever applies, in response to the following questions. Your answers are for our records only and are considered confidential.

Dental

1. In the last 10 years have you had your teeth cleaned in a dental office? _____ How often? _____
2. Date of your last dental visit? _____
3. Are you having any discomfort at this time? Explain _____ Yes No
4. Have you ever had any serious trouble associated with previous dental treatment? Yes No
5. Does dental treatment make you nervous? No Slightly Moderately Extremely
6. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
7. How often do you brush? _____
Floss? _____
8. Do your parents or brothers/sisters have dentures.....Yes No
9. Do you have or have you ever had any of the following?

Mouth	Teeth
Bleeding/sore gums..... Yes No	Loose Teeth..... Yes No
Unpleasant taste/bad breath... Yes No	Sensitive to hot..... Yes No
Burning tongue/lips..... Yes No	Sensitive to cold..... Yes No
Frequent blisters, lips/mouth..... Yes No	Sensitive to sweets..... Yes No
Swelling/lumps in mouth. Yes No	Sensitive to biting..... Yes No
Ortho treatments (braces)..... Yes No	Clenching/grinding of teeth.... Yes No
Biting cheeks/lips..... Yes No	If so, when.....
Clicking/popping jaw..... Yes No	Shifting of teeth..... Yes No
Difficulty opening or closing jaw... Yes No	Change in bite..... Yes No
10. Have you had any serious trouble associated with any previous dental treatment?..... Yes No
If so, please explain _____
11. Are you wearing removable dental appliances – splints _____ Nite guards _____ Other _____?
12. How do you feel about the appearance of your teeth _____

Medical

1. Has there been any change in your general health within the past year?..... Yes No
2. My last physical exam was on _____
3. Are you now under the care of a physician?..... Yes No
If so, what is the condition being treated? _____
4. The name and phone number of my physician is _____
5. Have you had any serious illness(s) within the past five (5) years?..... Yes No
Is so, what was the illness? _____
6. Have you been hospitalized or had an operation within the past five years..... Yes No
If so, for what? _____
7. Do you have or have you had any of the following diseases or problems?
 - a. Rheumatic fever or rheumatic heart disease, heart murmur or mitral valve prolapse... Yes No
 - b. Congenital heart disease..... Yes No
 - c. Inborn heart defects..... Yes No

MEDICAL HISTORY FORM -- PAGE TWO

- d. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.)... Yes No
 - 1. Do you have pain in chest upon exertion..... Yes No
 - 2. Are you ever short of breath after mild exercise..... Yes No
 - 3. Do your ankles swell..... Yes No
 - 4. Do you get short of breath when you lie down or do you require extra pillows at sleep..... Yes No
 - e. Pacemaker..... Yes No
 - f. Low blood pressure..... Yes No
 - g. Allergy..... Yes No
 - h. Sinus trouble..... Yes No
 - i. Asthma or hay fever..... Yes No
 - j. Respiratory problems, emphysema, etc..... Yes No
 - k. Thyroid problems..... Yes No
 - l. Hives or skin rash..... Yes No
 - m. Fainting spells or seizures..... Yes No
 - n. Epilepsy or any other neurological disease..... Yes No
 - o. Persistent diarrhea or weight loss..... Yes No
 - p. Diabetes..... Yes No
 - q. Is there diabetes in your family..... Yes No
 - r. Hepatitis, jaundice or liver disease..... Yes No
 - s. Arthritis or inflammatory rheumatism..... Yes No
 - t. Artificial or replacement joints..... Yes No
 - u. Digestive system – Ulcer or stomach disorders (colitis, hyperacidity).. Yes No
 - v. Kidney trouble..... Yes No
 - w. Tuberculosis..... Yes No
 - x. Persistent cough or cough up blood..... Yes No
 - y. Sexually transmitted disease..... Yes No
 - z. Problems with mental health..... Yes No
 - aa. Cancer, including treatment for tumor or growth..... Yes No
 - bb. Problems with immune system..... Yes No
 - cc. Other (explain)..... Yes No
8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma. Yes No
- a. Do you bruise easily?..... Yes No
 - b. Have you ever required a blood transfusion..... Yes No
- If so, explain the circumstances and when _____
9. Do you have any blood disorder such as anemia..... Yes No
10. Have you had surgery or x-ray treatment for a tumor, growth or other condition..... Yes No
11. Are you allergic or have you reacted adversely to:
- | | |
|---|--------------------------------------|
| a. Local anesthetics..... Yes No | e. Aspirin..... Yes No |
| b. Penicillin or other antibiotics. Yes No | f. Iodine..... Yes No |
| c. Sulfa drugs..... Yes No | g. Codeine or other narcotics Yes No |
| d. Barbiturates, sedatives, sleeping pills.. Yes No | h. Latex..... Yes No |
- List allergies or reactions to any other medications or food:
-
12. Do you use any tobacco product..... Yes No a. What age did you start smoking? _____
- b. How many years have you smoked? _____
- c. At your peak how much per day? _____
13. Do you drink alcoholic beverages..... Yes No
- a. If yes, how much alcohol have you consumed in the last 24 hours? _____
 - b. Are you alcohol and/or drug dependent..... Yes No
 - c. If yes, have you received treatment Yes No
 - d. Do you use drugs or other substances for recreational purposes..... Yes No
 - e. If yes, please list _____

MEDICAL HISTORY FORM -- PAGE THREE

- f. Frequency of use (daily, weekly, etc)
g. Number of years of recreational drug use
14. Do you have any disease, condition or problem not listed that you think I should be aware of?
15. Are you employed in any situation that exposes you to x-rays or other ionizing radiation?
16. Are you wearing contact lenses?
17. Have you taken the medication "phen/fen"?

HIV Status: The following questions are very important to Dr. Morgan, his staff, and you. They are intended for therapeutic reasons only and the answers are confidential; however, they may be shared with subsequent treating dentists or physicians.

- 18. Have you ever tested positive for the HIV virus?
19. Do you have any reason to believe that you are at risk of being HIV positive?
20. Have you ever "shot up" drugs?
21. Have you ever had sex with a man or woman who has "shot up" drugs?

Women

- Are you pregnant?
Are you nursing?
Type of birth control used
a. None
b. Birth control pills/patch/implants
c. IUD
d. Hysterectomy/tubal ligation
e. Vasectomy (mate)
f. Condoms
g. Rhythm

Children

Please identify custodial parent/guardian

Name SS#
Address
Phone number (Home) (Work)

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at my next appointment.

Signature of Patient Date
Signature of Dentist Date

FINANCIAL TERMS AND AGREEMENT

PLEASE READ THIS CAREFULLY

It contains the terms by which we provide services to our patients. If you do not understand any part of these policies, or if you have any questions, please ask before signing.

Financial Policy

We share patients concern with regard to the cost of dental care. In order to prevent unnecessary fees, we expect payment the day the service is rendered regardless of the insurance status of the patient. For a new patient consultation and for all sedation visits we require pre-payment of the entire amount. For new patient examinations we require payment in full the day of the visit. If the patient has dental insurance that may apply in these instances we would be happy to supply documentation to allow reimbursement to the patient.

For our patients with dental insurance, the following policy will apply following the initial examination appointment (for subsequent work):

Insurance Policy

If your insurance company will reimburse this office: We will submit your claim to your insurance carrier for payment of the services rendered. When insurance payment is received, we will bill you for any remaining balance. Payment of the remaining balance is to be paid in full within 30 days. However, if your insurance company does not respond within 30 days from the date of service, you will be billed for the complete amount due. Any questions you have regarding what services are covered (and in what amount) must be addressed with the insurance company directly. This office is not authorized to act on your behalf to secure the desired result from your insurance company. We do want to extend to all our patients the ability to receive quality dental care, but making sure your insurance company follows through on your claim is your responsibility. We submit your claims as a courtesy to you, but your insurance company has no binding contract to be of service to our office. They do with you.

If you're insurance company will only reimburse you, the patient or subscriber, then payment in full is required at the time the service is rendered. We will file an insurance claim for you.

Payment Plans and Options

We expect payment in full for all treatment at the time of service. We also offer payment by MasterCard, Visa, or Discover. If you would like to explore payment options through Citibank and/or Capital One, please ask our office staff for those brochures.

Missed Appointment and Cancellation Policy

We believe that every patient has the right to expect our full attention. To this end it is our policy to schedule one patient at a time. This means that if you do not show up for an appointment, or give less than 48 weekday hours notice to change an appointment, we are unable to re-book this time with another patient. Therefore, there is a charge of \$75.00 (or \$25.00 for each fifteen minutes of your scheduled appointment)--whichever is larger--should you break it. We confirm appointments as a courtesy to you. There is no guarantee that we will be able to reach you. You are responsible for the missed appointment charge whether we are able to reach you or not. Please consider your appointment card and/or mailed postcard as your confirmation.

Payments Made by Check

All checks should be made payable to Dr. Russ Morgan. Any check(s) returned to our office for insufficient funds are subject to a returned check fee of \$35.00. If this occurs, the amount of the check plus the returned check fee is due immediately in the form of cash, money order or certified funds.

Delinquent Account Policy

I completely understand that as a patient, and/or person financially responsible for this account, I will be held responsible for any and all fees for services rendered by Dr. Morgan. I understand that I am responsible for any costs involved in collecting a balance due. Accounts over 90 days past due will be turned over to a collection agency. If your account has to be placed in collections the following fees will apply: all court costs plus attorney's fees plus **40%** collection agency fees. Our collection services and fees are subject to change without prior notification.

Please feel comfortable in discussing any financial concerns with our office manager.

I HAVE READ THE ABOVE AND AGREE TO ACCEPT ALL FINANCIAL RESPONSIBILITY. We require a parent or legal guardian to sign this agreement for any minor children.

Patient's Name (Printed)

Date

Signature Of Responsible Party

Relationship to Patient

6/13/06