PATTON SMILES
creating smiles that last
Todd E. Patton, DDS

104 Forbes Street
Suite 204
Annapolis, MD 21401
410.295.1000 ph 410.295.1001 fax
WWW.PATTONSMILES.COM

Date: _____

Patient Information

Name of Patient: _____ Birthdate: ____/____/____
(Last Name, First Name)

Gender: ❍ M ❍ F Age: _____ Nickname: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Mailing Address: _____
(Street, City, State, Zip)

How did you hear about our practice? _____ Friend's Name (if applicable): _____

Emergency Contact: _____ Phone Number: _____

Responsible Party

Name of person responsible for this account (if someone other than yourself): _____
(Last Name, First Name)

Relationship: _____ DL: _____ SSN: _____ Birthdate: ____/____/____

Home Phone: _____ Cell Phone: _____ Email: _____

Mailing Address: _____

Employer: _____ Work Phone: _____

Is responsible party currently a patient in our office? ❍ Yes ❍ No

Insurance Information

Primary Insurance

Do you have insurance to assist you with payment? ❍ Yes ❍ No

Name of insured: _____

Relationship: _____ SSN: _____

Birthdate: ____/____/____ Work Phone: _____

Employer: _____

Employer Address: _____

Insurance Co.: _____ Group #: _____

Do you have a deductible? ❍ Yes (Amount: $_____) ❍ No

Do you know your maximum annual benefit? ❍ Yes (Amount: $_____) ❍ No

Have you used this insurance at a dental practice before? ❍ Yes ❍ No

Secondary Insurance

Do you have insurance to assist you with payment? ❍ Yes ❍ No

Name of insured: _____

Relationship: _____ SSN: _____

Birthdate: ____/____/____ Work Phone: _____

Employer: _____

Employer Address: _____

Insurance Co.: _____ Group #: _____

Do you have a deductible? ❍ Yes (Amount: $_____) ❍ No

Do you know your maximum annual benefit? ❍ Yes (Amount: $_____) ❍ No

Have you used this insurance at a dental practice before? ❍ Yes ❍ No

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Medical History

Name:_____Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you allergic to any of the following?

❍ Aspirin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal ❍ Latex/Rubber ❍ Local Anesthetics ❍ Sulfa Drugs ❍ Other: _____

1. Are you under a physician's care now? ❍ Yes ❍ No
2. Physician's Name:

_____

3. Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No
4. Have you ever had a serious head or neck injury? ❍ Yes ❍ No
5. Are you on a special diet? ❍ Yes ❍ No
6. Do you take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No
7. Are you taking any prescription, non-prescription or herbal medications? ❍ Yes ❍ No

If yes, please list medications:

_____

_____

8. Do you have, or have you ever had:

A. Scarlet or rheumatic fever ❍ Yes ❍ No
B. Congenital heart disease ❍ Yes ❍ No
C. Cardiovascular disease (heart) ❍ Yes ❍ No
- Angina (chest pain) ❍ Yes ❍ No
- Damaged heart valve ❍ Yes ❍ No
- Heart murmur ❍ Yes ❍ No
- Heart attack ❍ Yes ❍ No
  - If yes, when? _____
- Heart surgery ❍ Yes ❍ No
  - If yes, when? _____
- High blood pressure ❍ Yes ❍ No
- Low blood pressure ❍ Yes ❍ No
- Pacemaker ❍ Yes ❍ No
- Stroke ❍ Yes ❍ No

D. Lung disease ❍ Yes ❍ No
- Asthma ❍ Yes ❍ No
- Bronchitis ❍ Yes ❍ No
- Emphysema ❍ Yes ❍ No
- Shortness of breath ❍ Yes ❍ No
- Tuberculosis ❍ Yes ❍ No

E. Nervous disorder ❍ Yes ❍ No
- Epilepsy ❍ Yes ❍ No
- Seizures ❍ Yes ❍ No
- Fainting ❍ Yes ❍ No
- Breakdown ❍ Yes ❍ No
- Psychiatric treatment ❍ Yes ❍ No

F. Blood disorder ❍ Yes ❍ No
- Anemia ❍ Yes ❍ No
- Bleeding disorder ❍ Yes ❍ No
- Bleed or bruise easily ❍ Yes ❍ No

G. Kidney disease ❍ Yes ❍ No
H. Liver disease ❍ Yes ❍ No
- Hepatitis ❍ Yes ❍ No

I. Diabetes ❍ Yes ❍ No
J. Thyroid disease ❍ Yes ❍ No
K. Glaucoma ❍ Yes ❍ No
L. Cancer treatment ❍ Yes ❍ No
- Surgery ❍ Yes ❍ No
- Radiation ❍ Yes ❍ No
- Chemotherapy ❍ Yes ❍ No
- Oral drugs for cancer treatment ❍ Yes ❍ No

M. Bone disease/joint replacement ❍ Yes ❍ No
- Osteoporosis ❍ Yes ❍ No

N. Immune system ❍ Yes ❍ No
- Organ/tissue transplant ❍ Yes ❍ No
- AIDS ❍ Yes ❍ No
- HIV-Positive ❍ Yes ❍ No

9. Is it difficult opening your mouth? ❍ Yes ❍ No
10. Do you use controlled substances? ❍ Yes ❍ No
11. Are you wearing removable dentures or plate(s)? ❍ Yes ❍ No
12. Have you or anyone in your immediate family had difficulty with general anesthesia? ❍ Yes ❍ No
13. Do you snore? ❍ Yes ❍ No
14. Do you have sleep apnea? ❍ Yes ❍ No
15. Are you wearing contact lenses? ❍ Yes ❍ No
16. Do you have oral or facial piercing? ❍ Yes ❍ No
17. Do you smoke/use tobacco products? ❍ Yes ❍ No
    Amount:_____ Years:_____
18. Do you have a disease or condition not listed above? ❍ Yes ❍ No

Please list: _____

_____

_____

19. Do you wish to speak to the doctor privately about any concerns or questions? ❍ Yes ❍ No

FOR WOMEN ONLY:

Are you:
Pregnant or trying to get pregnant? ❍ Yes ❍ No
If you are pregnant, how far along? _____
Taking Oral Contraceptives? ❍ Yes ❍ No
Nursing? ❍ Yes ❍ No

Medical History Reviewed by Dr. _____ Date:_____

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Practice Financial Policy

We are committed to providing you and your family with the best possible care and are pleased to discuss our professional fees and your insurance coverage with you at any time. Your clear understanding of our financial and insurance policies is important to our relationship. Please ask us, at any time, if you have any questions about this policy.

• All patients must complete and sign the Patient Registration and Medical History form before seeing the doctor.

• We accept most insurance plans and will gladly process your claim. Please notify us of any changes in your insurance plan and bring your current insurance card to each visit. Insurance policies generally cover only a portion of the total treatment cost. *Unless other arrangements have been made, we ask that you pay your portion of the bill at the time of treatment. It is your responsibility to pay any balance not paid by your insurance company.*

• For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover. and American Express. Financing is also available through Care Credit.

• Patton Smiles reserves the right to charge a $75 fee for any appointment that has been canceled or broken less than 24 hours prior to scheduled appointment time.

• Treatment plans may change and you will be responsible for the treatment actually completed.

• For your convenience, this office may release your information to your insurance company and receive payment directly from them. Every effort will be made to help you with your insurance, however, the insurance company, not our office, determines the dental benefits that you receive. The estimated insurance coverage is not a guarantee of payment and is between you and the insurance company. All charges are your responsibility. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage.

• If sent to collections, you understand that it is your full financial responsibility to pay all court costs and all collection fees and/or attorneys fees.

Authorization

I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I may be billed for any remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf and of my dependents (if any).

I have been given access to a copy of the Notice of Privacy Practices.

_____ By checking here, I acknowledge that I have read the previous statements and agree to the contents.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

Print Name: _____

Signature:_____ Date:_____ Relationship to patient:_____

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Name: _____Date: _____

Patient Habits

Although you may not be aware, many common habits can affect your oral health.
Please take a moment to review the chart below and indicate which box reflects your habits.
Your honesty is important and, as always, your responses will remain confidential.

Habit	I do this now	I used to do this	How long?	How much?	I don't do this
Grind your teeth					
Bite or chew your cheek					
Bulimia / Anorexia					
Smoke cigars or cigarettes					
Smoke pipe					
Chew tobacco					
Bite nails					
Suck thumb or finger					
Use a toothpick or stimulator					
Chew gum					
Eat candy					
Drink soft drinks					
Crunch hard foods (like popcorn)					
Chew ice					
Suck on mints or candies					
Use recreational drugs					

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ViziLite Plus Exam

ViziLite® Plus
ORAL LESION IDENTIFICATION AND MARKING SYSTEM

This enhanced examination is recognized by tile America Dental Association code revision committee as CDT-09 procedure code D0431. Our office experience tells us that your insurance carrier most likely will NOT cover this expense. The fee for this enhanced oral cancer screening test is $69.00.

Increased Risk: Patients ages 18-39
High Risk: patients age 40+: tobacco user (any age. any type within 10 years)
Highest Risk: patients age 40+ with risk factors (tobacco and/or alcohol use); previous history of oral cancer

An annual ViziLite Plus exam, in combination with a regular visual examination, provides a comprehensive oral screening procedure for patients at increased risk for oral cancer. The Vizilite Plus exam is painless and fast, and could help save your life.

- First, you will be instructed to rinse with a cleansing solution.
- Next, the overhead lighting will be dimmed.
- Then. we will examine your mouth using Vizilite Plus, a specially designed light technology.

You are: ❍ **Highest Risk** ❍ **High Risk** ❍ **Increased Risk**

Yes. I authorize Patton Smiles to perform the Vizilite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print Name:_____

Signature: _____ Date: _____

No, I would prefer not to have the ViziLite Plus exam at this time.

Print Name:_____

Signature: _____ Date: _____

Please return this form to the hygienist or other staff member. Thank you!

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Notice of Privacy Practices Acknowledgement & Consent (HIPAA)

TODD E. PATTON, D.D.S., L.L.C

By signing below, I acknowledge that I have been given access to a copy of the Todd E. Patton, D.D.S., L.L.C. Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control of this information. By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

Print name of patient, parent or guardian:_____ Date:_____

Signature:_____ Relationship to patient:_____

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Name:_____

Patient Consent for Use of Electronic Mail (E-Mail)

PLEASE PRINT:

Patient Name:_____ Date:_____

Address:_____
Street City State Zip

Patient E-mail address:_____

Medical Record Number:_____

1. RISK OF USING E-MAIL

Patton Smiles offers patients the opportunity to communicate with the practice and/or clinicians by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before giving consent. These risks include, but are not limited to:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.

b. E-mail can be immediately broadcast worldwide and be received by both intended and unintended recipients.

c. E-mail senders can misaddress e-mail.

d. E-mail can be more easily falsified than handwritten or signed documents.

e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.

f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.

g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

h. E-mail can be used to introduce viruses into computer systems.

i. E-mail can be used as evidence in court.

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Name:_____

Patient Consent for Use of Electronic Mail (E-Mail)

2. CONDITIONS FOR THE USE OF E-MAIL

Patton Smiles will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Patton Smiles cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

a. All emails to or from the patient concerning diagnosis or treatment will be made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.

b. Patton Smiles may forward e-mails internally to Patton Smiles' staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Patton Smiles will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.

c. Although Patton Smiles will endeavor to read and respond promptly to e-mail from the patient, Patton Smiles cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time-sensitive matters.

d. If the patient's e-mail requires or invites a response from Patton Smiles, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, issues of abuse, developmental disability, or substance abuse.

f. The patient is responsible for informing Patton Smiles of any types of information the patient does not want to be sent by e-mail, in addition to hose set out in (e) above.

g. The patient is responsible for protecting his/her password or other means of access to e-mail. Patton Smiles is not liable for breaches of confidentiality caused by the patient or any third party.

h. Patton Smiles shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

i. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

Continues next page...

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Patient Consent for Use of Electronic Mail (E-Mail)

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

a. Limit or avoid use of his/her employer's computer.

b. Inform Patton Smiles of changes in his/her e-mail address.

c. Put his/her name in the body of the e-mail.

d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing questions).

e. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to the Provider.

f. Inform Patton Smiles that the patient received e-mail from Patton Smiles.

g. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.

h. Withdraw consent only by e-mail or written communication to the Provider.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Print name of patient, parent or guardian:_____ Date:_____

Witness Signature:_____ Date:_____