ELLIOTT
FAMILY DENTISTRY

Jason P. Elliott, DDS
809 N Hammonds Ferry Rd.
Linthicum, MD 21090
(410) 789-6111

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____ Mr I Dr I Mrs I Miss I Ms
Mailing Address: (Street, City, State, Zip) _____
Birthday: _____ Male Female Single Married Widowed Divorced
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ Do you want Email reminders? Yes No
Social Security Number: _____ Drivers License Number: _____
Occupation: _____ Employer: _____ Employer Phone: _____
Employer Address: (Street, City, State, Zip) _____

In Case Of Emergency Contact:

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Whom can we thank for referring you to us? _____

Account Information

☐ Person responsible for this account is the same as above
Last Name: _____ First Name: _____ Middle Initial: _____ Mr I Dr I Mrs I Miss I Ms
Mailing Address: (Street, City, State, Zip) _____
Birthday: _____ Male Female Single Married Widowed Divorced
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ Do you want Email reminders? Yes No
Social Security Number: _____ Drivers License Number: _____
Occupation: _____ Employer: _____ Employer Phone: _____
Employer Address: (Street, City, State, Zip) _____
Insurance Company: _____ ID Number: _____ Group Number: _____

☐ Additional Insurance
Last Name: _____ First Name: _____ Middle Initial: _____ Mr I Dr I Mrs I Miss I Ms
Mailing Address: (Street, City, State, Zip) _____
Birthday: _____ Male Female Single Married Widowed Divorced
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ Do you want Email reminders? Yes No
Social Security Number: _____ Drivers License Number: _____
Occupation: _____ Employer: _____ Employer Phone: _____
Employer Address: (Street, City, State, Zip) _____
Insurance Company: _____ ID Number: _____ Group Number: _____

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient.

I understand that I am responsible for all costs of dental treatment. I aulhorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all infomation necessary to secure payment of benefits.

Patient or Responsible Party Signature: X _____ Date:_____

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Medical History:

Although our Dental Team primarily treats areas in and around your mouth the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible, Thank You!

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain:_____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
Have you ever had a serious head or neck injury? ☐ Yes ☐ No
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No
Please list any medications, pills, or drugs you are taking: _____
_____

Women:
Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Cortisne Medicine	☐ Hemophilia	☐ Renal Dialysis	☐ Other Serious Illness
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitus A,B, or C	☐ Rheumatic Fever	Please Explain: _____
☐ Anaphylaxis	☐ Drug Addiction	☐ Headaches	☐ Rheumatism	_____
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Scarlet Fever	_____
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Shingles	_____
☐ Arthritis / Gout	☐ Epilepy or Siezures	☐ Hives or Rash	☐ Sickle Cell Disease	_____
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble	_____
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida	_____
☐ Asthma	☐ Fainting Spells / Diziness	☐ Kidney Problemes	☐ Stomach Disease	_____
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Intestinal Disease	_____
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Stroke	_____
☐ Breathing Problems	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Swelling of Limbs	_____
☐ Bruise easily	☐ Genital Herpes	☐ Lung Disease	☐ Thyroid Disease	_____
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Problems	☐ Tonsilitis	_____
☐ Chemotherapy	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Tuberculosis	_____
☐ Chest Pains	☐ Heart Attack / Failure	☐ Parathyroid Disease	☐ Tumors or Growths	_____
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Psychiatric Care	☐ Ulcers	_____
☐ Congenital Heart Disease	☐ Heart Pace Maker	☐ Radiation Treatments	☐ Venereal Disease	_____
☐ Convulsions	☐ Heart Trouble / Disease	☐ Recent Weight Loss	☐ Yellow Jaundice	_____

Signature:

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health I will not hold my Dentist or any members of his/her Dental Team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: X _____ Date:_____

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HIPPA Act:

How the Health Insurance Portability and Accountability Act (HIPAA) Will Affect Your Next Dental Visit

The US Department of Health and Human Services has recently issued national health information privacy standards. The Health Insurance Portability and Accountability Act, a federally mandated law known as HIPAA, is designed to:

- provide protection for the privacy ofcertain identifiable healflt data (callel protected health infornatio\ [PHI]),
- ensure health insurance coverage when changing employers, and
- provide standards for facilitating electronic transfers of health care-related information.

While the privacy of your personal PHI will remain confidential, certain aspects of this law will permit disclosures of PHI to facilitate public health activities. The following charts review the types of health dated disclosure allowed under HIPAA.

PHI can be disclosed with your authorization in the following categories.

You may request a limitation or restriction on the disclosure of this information. You have the right to:

- request a restriction or limit of any of the above disclosures used for treatment, payment, or office operations.
- inspect and copy information that may be used to make decisions about your care.
- request an amendment of this information if you feel it is incorrect or incomplete.
- an accounting of disclosures we have made that were not related to treatment, payment, or operations of this office.

These requests must be submitted in writing to the office manager and you will be informed of the specifics that are required.

Treatment - PHI will be used to provide appropriate treatment either by this office or other healthcare providers, diagnostic or fabrication laboratories.

Payment - PHI will be used to facilitate payment for treatment rendered. Your health plan requires this information in order to bill, collect payments, or obtain approval prior to treatment.

Healthcare Operations - In order to ensure all patients receive timely and quality care, PHI will be used to facilitate the daily operations of our practice. These include, but are not limited to:

- clinical/research studies to improve our practice
- appointment reminders by phone calls or mailings
- sign-in sheets used to notify us of your arrival
- posted appointment schedules
- information regarding your treatment options or related benefits and services
- communications with family or friends that are involved in your care or payment for your care

PHI can be disclosed without your authorization in the following categories.

As Required by Law	Judicial & Administrative Proceedings	Oversight PHI can be disclosed to a health oversight agency as authorized by law for audits, investigations, inspections, and licensure.
Public Health	Lawsuits & Disputes	Workers' Compensation PHI may be released to workers' compensation or similar programs that provide benefits for work-related injuries or illness.
Public Health Risks	Law Enforcement	Military & Veterans
Health Research PHI disclosuresa rep ermined when required by federal, state, tribal. or local laws.	Coroners & Medical Examiners Release of PHI to officials will occur: in response to a court order, subpoena, discovery request or summons; to identify a suspected fugitive, witness, or missing person; about a victim of crime if unable to obtain permission from the person; to identify a deceased person, determine cause of death, about a death that is believed to be the result of criminal conduct; criminal conduct occurring at the practice; in emergency situations.	National Security and Intelligence Activities
Abuse, Neglect, or Domestic Violence PHI can be disclosedto preventa threat to your health and safety or the health and safetv of others.	Cadaver Organ, Eye, or Tissue Donations PHI disclosure can be made to organ banks as necessary to facilitate organ or tissue donation and transplantation.	Protective Services for the President & Others PHI may be released as authorized by law when requested by military command authorities, federal officials for national security, and protection of the president and other heads of state.