PATIENT MEDICAL HISTORY

Date_____

Name_____ Nickname_____

Birth date _____ SS#_____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone_____ Work Phone _____

E-mail _____ Sex: M ☐ F ☐

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Referred by _____

Employer _____ Occupation _____

Emergency Contact Person _____ Relationship_____ Phone_____

Do you have Dental Insurance Y☐ N☐ Insurance plan_____ ID #_____

Are you taking any medications? Y ☐ N ☐
If yes, list below:

Allergies

Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Metals
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Dental Anesthetics	☐	☐	Tetracycline
☐	☐	Erythromycin	☐	☐	Latex
☐	☐	**OTHER** _____	☐	☐	Jewelry

_____

Dental concerns or problems _____

Date of last dental visit _____

Do you need to be pre-medicated before dental treatment? _____ If so, why? _____

Please answer the following:

Y N
☐ ☐ Do you smoke or use tobacco?
How much? _____
Height _____ Weight _____

If female:

Y N
☐ ☐ Are you taking Birth Control Pills?
☐ ☐ Are you pregnant? If yes, # of weeks_____
☐ ☐ Are you nursing?

For office use only
BP_____/_____

Heart rate _____

Have you had any illnesses or hospitalizations within the past year? Is there any disease, condition, or problem that you think this office should know about? If so, please describe below.

Physician's name _____ Physician's phone number _____

Y	N	CONDITIONS
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones/Joints
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Thinner (Warfarin)
☐	☐	Blood Transfusion
☐	☐	Cancer-Chemotherapy
☐	☐	Congenital Heart Valve
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse

Y	N	CONDITIONS
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters/Ulcers
☐	☐	Frequent Headaches
☐	☐	GERD
☐	☐	Glaucoma
☐	☐	HIV/ AIDS
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B/C
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure

Y	N	CONDITIONS
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pain in Jaw Joints
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Seizures
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	**Other** If yes, please describe:

_____
_____
_____

Signature_____ Date_____

(If under 18, Parent or Guardian Signature Required)

INSURANCE INFORMATION

Date_____

_____ _____
Patient Name Patient Birth date

RESPONSIBLE PARTY

Name of Person
Responsible for this Account_____ Relationship to patient_____

Social Security Number_____

Primary Insurance

Employee _____ Relationship to Patient_____

Birth date_____ Date employed_____

Employer_____ Work phone_____

Insurance Company_____ Group#_____ ID#_____

Insurance Address_____ City _____ State_____ Zip_____

Insurance Company Phone_____

Secondary Insurance

Employee_____ Relationship to Patient_____

Birth date_____ Social Security #_____ Date employed_____

Employer_____ Work phone_____

Insurance Company_____ Group#_____ ID#_____

Insurance Address_____ City _____ State_____ Zip_____

Insurance Company Phone_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct.
I certify that I, and/or my dependant(s) have insurance coverage with _____and assign directly
Name of Insurance Company(ies)
to Dr. Lewis S. Libby III all insurance benefits, if any, otherwise payable to me for services rendered.
I have read the contents of the Notice of Privacy Practices. I understand that Dr Lewis S. Libby III may use my healthcare information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end one year from the date signed below.

_____ _____
Signature of Patient, Parent, or Guardian or Personal Representative Date

_____ _____
Please print Relationship to Patient

FINANCIAL POLICY AND RESPONSIBILITY AGREEMENT

Thank you for choosing Osler Dental Professionals as your dental care provider. We are committed to providing you the highest quality dental care and customer service, so that you may attain optimum oral health.

We believe your understanding of our financial policy is vital to the Provider-Patient relationship and our goal is not only to inform you of the provisional aspects of this policy, but to keep the lines of communication open regarding them.

OUR FINANCIAL POLICY

1. Payment is due at the time service is provided unless other arrangements are made with our office.
2. We accept Cash, Personal Checks, Visa, MasterCard, Discover and American Express.
3. All quotes are estimates only.
4. Financing is available through LendingClub. Please visit for more details about their approval process and flexible payment options.

FOR PATIENTS WITH DENTAL INSURANCE

We are Out-Of-Network with all insurance carriers. However, if you have a PPO plan, we will submit your insurance claims to help you receive the maximum allowable benefits under your policy. Please remember that your insurance policy is a contract between you and your insurance carrier. Be aware that some (or perhaps all of the services provided) may not be covered by your insurance plan and any balance incurred is your responsibility - whether or not your insurance company pays any portion.

CANCELLATIONS & MISSED APPOINTMENTS

We understand that personal emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, late-notice cancellations and missed appointments prevent us from being able to fulfill the scheduling needs of other patients. **Please provide our office with 24-hour notice if you need to cancel or change an appointment.** Missed appointments - and appointments that are canceled with less than 24-hour notice - may be subject to a fee. ***If a patient has multiple missed appointments or late-notice cancellations, it may result in dismissal from our practice.***

PAST DUE BALANCES

We realize that temporary financial issues may affect timely payment. If this should occur, please contact our office to discuss management of your account. Our goal is to always provide quality care and service.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY AND RESPONSIBILITY AGREEMENT. I AGREE TO COMPLY WITH ALL OF THE TERMS AND CONDITIONS, AND I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR THIS ACCOUNT.

Print Patient Name: _____ Date: _____

Signature of Patient or Parent/Guardian: _____

LEWIS S. LIBBY III D.D.S.
CHRISTOPHER J. CONSTANTINE D.D.S.
7600 Osler Drive
Suite 100
Towson, Maryland 21204
410-321-1144

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

CONTACT PERSON **Sue Spivey**
7600 Osler Drive Suite 100, Towson, MD 21204

PATIENT /GUARDIAN GIVING CONSENT

Name _____

City _____ State_____ Zip _____

PLEASE READ THE FOLLOWING STATEMENT 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.

Our **Notice of Privacy Practices** are listed on the back of this page. Please take time to read it carefully.

Right to Revoke: You 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.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and 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 patient is under age 18 :
Personal Representative _____

Relationship to patient _____

You are entitled to a copy of this consent after you sign it

OSLER DENTAL PROFESSIONALS

7600 Osler Drive
Suite 100
Towson, MD 21204
410-321-1144

HIPAA EMAIL CONSENT

HIPAA stands for the Health Insurance Portability and Accountability Act.

HIPAA was passed by the U.S. Government in 1996 in order to establish privacy and security protections for health information.

Information stored in our computers is encrypted.

Most popular email services (i.e. Hotmail, Gmail, Yahoo) do not utilize encrypted email.

When we send you an email or you send us an email the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you someone may be able to access your email account and read it.

Email is a very popular and convenient way to communicate for a lot of people. The federal government has provided guidance on email and HIPPA in their latest modification to the HIPAA Act.

The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website: http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

The guidelines state that if a patient has been made aware of the risks of unencrypted email and that same patient provides consent to receive health information via email then an entity may send that patient personal medical information via unencrypted email.

OPTION 1
ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Osler Dental Professionals to send me personal health information via unencrypted email.

Email Address _____

Signature _____ Date _____
(parent or guardian if minor)

OPTION 2
DO NOT ALLOW ENCRYPTED EMAIL

I do not wish to receive personal health information via email.

Signature _____ Date _____
(parent or guardian if minor)

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 IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state 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. This Notice takes effect APRIL 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We 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 a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

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, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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, 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 reasonable, cost-based 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. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), 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, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, 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 will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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 Officer: SUE SPIVEY

Telephone: 410-321-1144 Fax: _____

E-mail: _____

Address: 7600 OSLER DRIVE SUITE 100 TOWSON, MARYLAND 21204

Consent for Photo/Video Records

Osler Dental Professionals
7600 Osler Drive, Ste 100
Towson, MD 21204

I,_____, hereby authorize Osler Dental Professionals or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications, and educational lectures. The content may also be used for advertising purposes.

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information will not be used. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Please initial one option:

_____I agree to the use of photographs in any of the above stated situations.

_____I only agree to have my teeth shown without any identifying features.

_____ I do not consent to the use of photographs in any of the above stated situations

Signed_____Date_____