EASTERN Shore ENDODONTICS

1411 Wesley Drive • Salisbury, MD 21801 • 410-742-7007

D. MARCUS FORNO, D.D.S.

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Address: _____
Street City State Zip Code

Phone # (Home): _____ (Work): _____ext_____ (Cell): _____

Sex: ☐ Male ☐ Female

Martial Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced ☐ Child, School: _____

Social Security #: _____ Birth Date: _____ Age: _____

Employer Name: _____ Occupation: _____ ☐ FT ☐ PT

In case of emergency, contact: _____ Phone #: _____ Relationship: _____

Please list the name of the dentist who referred you to this office:_____

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: _____ Spouse/Parent Employer: _____

Social Security #: _____ Birth Date: _____

RESPONSIBLE PARTY (ONLY COMPLETE IF DIFFERENT THAN ABOVE)

Person responsible for account: _____

Address: _____
Street City State Zip Code

INSURANCE INFORMATION

Insured Name: _____ Daytime Phone: _____
Last First MI

Insured Address: _____
Street City State Zip Code

Employer: _____ Social Security #: _____ Birth Date: _____

Insurance Company Name:_____

ID #: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or the above-named patient, have insurance coverage with the above-named insurance company and assign directly to Eastern Shore Endodontics, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named dentist(s) many use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatments completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, Responsible Party, Insured Printed Name of Patient, Parent, Guardian, Responsible Party, Insured

_____ _____
Date Date

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HEALTH HISTORY

Name of Physician: _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ No ☐ Yes, explain: _____

Are you currently taking prescription medication? ☐ No ☐ Yes, List Meds: _____

_____

Are you allergic to any medications, anesthetics, or latex? ☐ No ☐ Yes, explain: _____

Has it been recommended that you take antibiotic pre-medication prior to any or all dental treatment? ☐ No ☐ Yes

Please check Yes or No to indicate if you have ever had any of the following. If yes, please explain below:

AIDS/HIV	☐ No	☐ Yes	Excessive Bleeding	☐ No	☐ Yes	Pacemaker	☐ No	☐ Yes
Anemia	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes	Radiation Treatment	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes	Hay Fever	☐ No	☐ Yes	Respiratory Problems	☐ No	☐ Yes
Artificial Joints	☐ No	☐ Yes	Heart Disease	☐ No	☐ Yes	Rheumatic Fever	☐ No	☐ Yes
Asthma	☐ No	☐ Yes	Heart Surgery	☐ No	☐ Yes	Sinus Problems	☐ No	☐ Yes
Cancer/Tumors	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes	Stomach Problems	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Hepatitis/Jaundice	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Dizziness/Fainting	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes
Epilepsy	☐ No	☐ Yes	Mental Disorder	☐ No	☐ Yes	Venereal Disease	☐ No	☐ Yes

Women: Are you pregnant? ☐ No ☐ Yes, number of weeks _____ Are you taking birth control pills? ☐ No ☐ Yes

Comments: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I will not hold the dentist or any staff member liable, or in any way responsible, for any complications resulting from any errors or omissions that I may have made in completion of this form. If I ever have any change in my health, I will inform the dentist immediately without fail.

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

Office Use Only

Health History reviewed by: _____ _____

Signature of Dentist Date

Comments: _____

Medical Alerts: _____

INSURANCE INFORMATION

As a condition of your treatment by this office, financial arrangements must be made prior to treatment. An estimate of your total fees and any estimated insurance benefits, if applicable, will be given to you prior to treatment. Estimated insurance benefits are provided as a courtesy and are not guarantees of any insurance payment or coverage. Please note that this is an estimate and any changes to your treatment plan or unanticipated complexities arising during treatment may change the estimate. All dental services rendered must be paid in full at the time of service unless prior financial arrangements have been made. For your convenience we accept MasterCard, Visa, Discover, American Express, cash, check, or money order.

Dental Insurance: Please remember that insurance plans are contracts between the patient, the employer, and the insurance company. If we are a participating provider with our dental insurance, we will submit a dental claim form for any benefits payable to be assigned directly to this office for dental services rendered. ***ALL ESTIMATED CO-PAYS AND DEDUCTIBLES, AND PROCEDURES NOT COVERED BY INSURANCE , MUST BE PAID IN FULL AT THE TIME OF SERVICE.*** If your dental insurance company does not remit payment within 30 days, as required by Maryland State law, the unpaid balance will be your responsibility.

We reserve the right to charge a late payment fee of 1.75% interest per month (21% annually) on any unpaid balances exceeding 60 days. Accounts not paid in full within 90 days will be forwarded for collection activity and subject to additional collection and legal fees. There will be a $30 minimum fee charged for returned checks and full payment of the account balance, including the returned check fee, must be made in cash or by money order.

I certify that I have read, understand, and agree to the above terms and conditions of treatment and payment, and I accept full financial responsibility for all fees charged.

_____ _____ _____

Signature of Patient, Parent, Guardian, Responsible Party, Insured Date Relationship to Patient

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Authorization Form to Other Uses of Protected Health Information.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portablitity and Accountablitity Act of 1996 (HIPPA).

Specific description of the information to be used or disclosed, including specific purpose:

- For Medical Treatment
- Obtain payment for our services.
- For appointment reminders
- For continuing education
- In emergency situations
- Workers' compensation
- To run our Practice more effeciently and ensure all our patients receive quality care.
- In response to certain requests arising out of legal or other disputes.

Complete those that apply:

Individuals who may use or discloses PHI:

Eastern Shore Endodontics, P.A.

Others: _____

The entity involved in payment and referral sources.

The above-mentioned PHI may be subject to futher or re-disclosure by the party recieving the information and may no longer be protected by the privicy rules upon shuch disclosure. Your signature authorized us to use and disclose protected health information (PHI) as provided herein. You have the right to revoke the authorization at any time, in writing, signed by you and directed to our Privacy Officer or Office Manager. However, such revocation shall not affect any disclosures we have already made in reliance on you prior to authorization or consent.

This Authorization was signed by:

_____
Printed Name of Patient or Representative

_____
Date

_____
Signature of Patient or Representative

_____
Relationship to Patient

PATIENT CONSENT FORM

The practice provides this Consent form to comply with the Health Information Portablility Act of 1996 (HIPPA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patients' Rights section describing your rights under the law (HIPPA). You have the right to review our Notice before signing this Consent. If the terms of our notice changes, you may obtain a copy of said changes by contacting our office.

As for the Patient, you have the right to request that we restrict how protrected health information about you is used or disclosed for treatment, payment, and health care operations. We are not required to agree to this restriction but if we do, we shall honor that agreement.

By signing this form, you condent to our use and disclosure of PHI treatment, payment, and health care operations. You have the right to revoke the Consents, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made un reliance on your prior Consent.

The Patient Understands That:

- PHI may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this notice.
- The Practice reserves the right to restrict the uses of their PHI but the Practice does not have to agree to those restrictions.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treeatment upon the execution of the Consent.

This Consent was signed by:

_____
Printed Name of Patient or Representative

_____
Date

_____
Signature of Patient or Representative

_____
Relationship to Patient