# All Smiles Bethesda

**Jonathan Leung, DDS**
**Mary Ziomek, DDS**

Chart #: _____
FOR OFFICE USE ONLY

## Patient Information

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

Gender_____ Family Status_____ Social Security #: _____ Birth Date: _____

Driver's License #: _____ Email Address: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Ph: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #
City State Zip Code

## Health Information

Date of Last Dental Visit: _____ Dentist's Name: _____
Reason for this visit: _____

**Have you ever had any of the following? Please check those that apply:**

☐ HIV / AIDS
☐ Allergies _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur or Mitral Valve Prolapse
☐ Premedicated prior to dental treatment
☐ Hepatitis or Jaundice
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Periodontal treatment
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tooth Implants
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Are you taking any medication? ☐ Yes ☐ No What? _____
- History of TMJ? ___Yes ____ No If yes please explain:_____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

## Referral Information

Who may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Website ☐ School ☐ Work ☐ Other _____

Name of person or website referring you to our practice: _____

## Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

## Insurance Information

**Primary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

**Secondary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

## Consent for Dental Services

I confirm that I have come to the Dentist to obtain dental services. I consent and authorize examination and treatment as determined to be necessary by the Doctor or by her staff under her supervision.

Accuracy of Health Information.
I understand that the Doctor and her staff will rely on my answers to the HEALTH INFORMATION questionnaire, and affirm that my answers are true and complete. I agree to hold the Doctor and her staff harmless for any injury which I may suffer as a result of my failure to fully complete the HEALTH INFORMATION questionnaire truthfully and accurately.

Payment for Dental Services
I understand that I am fully responsible to pay for all services provided to me by the Doctor or her staff under her supervision at the time services are rendered. I understand that any insurance coverage I may have is for my personal benefit and does not release me from my obligation to pay for the services provided to me, at the time they are rendered. I agree that I am responsible to collect whatever benefits may be due from any insurance company. Neither the Doctor nor her staff has this responsibility. I acknowledge that if this office prepares and submits any insurance claim information on my behalf, it is done solely as a courtesy to me, and I agree to allow the Doctor to apply any payments received from my insurance company against any sum that I owe.

**I understand that I may be charged a missed appointment if 24 hour notice is not given before breaking or canceling.**

Collection of Overdue Accounts
I agree to pay the Doctor interest on my outstanding account at the rate of 1.5% per month, beginning 60 days after services are provided to me. I further agree to pay all attorney fees, court costs, or any other costs of collection if the Doctor incurs any such costs to collect money due on my account.

**I have read and agree to all of the above conditions of treatment and consent to allow you to speak with me at work or at home to discuss my treatment, condition, or account.**

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

# All Smiles Bethesda


## Jonathan Leung, DDS
## Mary Ziomek, DDS

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## HIPAA COMPLIANCE NOTICE FOR OUR PATIENTS

Dear Patient,

The misuse of personal health information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors have been trained to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the Privacy Rule. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a compliance program for our doctors and staff and our business associates that we believe will help us ensure your protection and appropriate use of your Personal Health Information.

We are careful to protect your privacy as much as possible in our office. Because of the physical design of our open treatment areas and our open-air front desk, we make an extra effort to protect your privacy. Please be assured that we are aware of these limitations and that we all take precautions necessary to protect your privacy at all times. If you have any suggestions or concerns, we would like to hear them so that we can continually train our staff and continue to make you feel protected and cared about in our office. We welcome your input and will make every effort to remedy any situation promptly.

### HIPAA COMPLIANCE NOTICE AND PATIENT CONSENT FOR

The Department of Health and Human Services has established a “Privacy Rule” to help ensure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide certain guidelines for healthcare providers to obtain their patients’ consent for uses and disclosures of health information about the patient in order to carry out treatment, payment or healthcare operations.

As our patient, we want you to know that we respect that privacy of your personal dental records and will do all we can to secure and protect your privacy. When appropriate, we provide the minimal necessary information to only those we feel are in need of your health information. This includes information about treatment, payment and/or healthcare operations that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationship with our business associates, such as laboratories, that only interact with doctors and our staff and not directly with patients, and may have to disclose personal health information for purposes of treatment, payment and healthcare operations.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, if you refuse to disclose your personal health information, we may have to exercise the right to refuse to treat you. If you choose to give consent to this document, at some future time, you may request in writing to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any questions regarding this form, please ask to speak to our HIPAA Compliance Officer, or Dr. Jonathan Leung. You have the right to review our privacy notice and to request restrictions and revoke consent in writing.

### Photo ID

Occasionally, insurance companies, as well as government-funded programs, require us to insure that we have verified the identity of a claimant. Therefore, we request a photo ID so that we can file claims for our patients rather than requiring them to file their own claims and having to pay in advance for treatment. We also cannot accept personal checks without a photo ID. We request to have a photo ID on file rather than having to ask at every visit.

Thank you for being a valued patient in our office.

Yours truly,
Jonathan Leung, DDS and Staff

I have read and agree to the statement above.

Allow access to _____ Relationship_____

Allow access to _____ Relationship_____

Allow access to _____ Relationship_____

Patient Signature:_____Date:_____