VINCENT F. FIORENTINO, D.D.S.
GENERAL DENTISTRY
21907 WESTERNPORT ROAD, SUITE 2 · WESTERNPORT, MD 21562 · TELEPHONE (301) 786-7340

MEDICAL HISTORY

Name: _____
Birthdate: _____

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 under a physician's care now? □ Yes □ No If yes, please explain:_____
Have you ever been hospitalized or had a major operation? □ Yes □ No If yes, please explain:_____
Have you ever had a serious head or neck injury? □ Yes □ No If yes, please explain:_____
Are you taking any medications, pills, or drugs? □ Yes □ No If yes, please explain:_____
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
Are you taking, or have you ever taken, Bisphosphonates? □ Yes □ No If yes, please explain:_____
(Foxamax, Actenol, Didronel, Zometa, Boniva, or others)?

Women: Are you Pregnant/Trying to get pregnant? □ Yes □ No Taking oral contraceptives? □ Yes □ No Nursing □ Yes □ No

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

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

AIDS/HIV Positive	□ Yes □ No	**Cortisone**	□ Yes □ No	**Hemophilia**	□ Yes □ No	**Renal Dialysis**	□ Yes □ No
Alzheimer's Disease	□ Yes □ No	**Diabetes**	□ Yes □ No	**Hepatitis A**	□ Yes □ No	**Rheumatic Fever**	□ Yes □ No
Anaphylaxis	□ Yes □ No	**Drug Addiction**	□ Yes □ No	**Hepatitis B or C**	□ Yes □ No	**Rheumatism**	□ Yes □ No
Anemia	□ Yes □ No	**Easily Winded**	□ Yes □ No	**Herpes**	□ Yes □ No	**Scarlet Fever**	□ Yes □ No
Angina	□ Yes □ No	**Emphysema**	□ Yes □ No	**High Blood Pressure**	□ Yes □ No	**Shingles**	□ Yes □ No
Arthritis/Gout	□ Yes □ No	**Epilepsy or Seizures**	□ Yes □ No	**Hives or Rash**	□ Yes □ No	**Sickle Cell Disease**	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	**Excessive Bleeding**	□ Yes □ No	**Hypoglycemia**	□ Yes □ No	**Sinus Trouble**	□ Yes □ No
Artifical Joint	□ Yes □ No	**Excessive Thurst**	□ Yes □ No	**Irregular Heartbeat**	□ Yes □ No	**Spina Bifida**	□ Yes □ No
Asthma	□ Yes □ No	**Fainting Spells/Dizziness**	□ Yes □ No	**Kidney Problems**	□ Yes □ No	**Stomach/Intestional Disease**	□ Yes □ No
Blood Disease	□ Yes □ No	**Frequent Cough**	□ Yes □ No	**Leukemia**	□ Yes □ No	**Stroke**	□ Yes □ No
Blood Transfusion	□ Yes □ No	**Frequent Diarrhea**	□ Yes □ No	**Liver Disease**	□ Yes □ No	**Swelling of Limbs**	□ Yes □ No
Breathing Problems	□ Yes □ No	**Frequent Headaches**	□ Yes □ No	**Low Blood Pressure**	□ Yes □ No	**Thyroid Disease**	□ Yes □ No
Bruise Easily	□ Yes □ No	**Genital Herpes**	□ Yes □ No	**Lung Disease**	□ Yes □ No	**Tonsillitis**	□ Yes □ No
Cancer	□ Yes □ No	**Glaucoma**	□ Yes □ No	**Mitral Valve Prolapse**	□ Yes □ No	**Tuberculosis**	□ Yes □ No
Chemotherapy	□ Yes □ No	**Hay Fever**	□ Yes □ No	**Pain in Jaw Joints**	□ Yes □ No	**Tumors or Growths**	□ Yes □ No
Chest Pains	□ Yes □ No	**Heart Attack/Failure**	□ Yes □ No	**Parathyroid Disease**	□ Yes □ No	**Ulcers**	□ Yes □ No
Cold Sores/Fever Blisters	□ Yes □ No	**Heart Murmur**	□ Yes □ No	**Psychiatric Care**	□ Yes □ No	**Venereal Disease**	□ Yes □ No
Congenital Heart Disorder	□ Yes □ No	**Heart Pace Maker**	□ Yes □ No	**Radiation Treatments**	□ Yes □ No	**Yellow Jaundice**	□ Yes □ No
Convulsions	□ Yes □ No	**Heart Trouble/Disease**	□ Yes □ No	**Recent Weight Loss**	□ Yes □ No		

Have you ever had any serious illnesses not listed above? □ Yes □ No If yes, please explain:_____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE_____

TODAY'S DATE: _____/_____/_____

E-MAIL ADDRESS: _____

LAST NAME:_____

FIRST NAME:_____ MIDDLE INITIAL: _____

I PREFER TO BE CALLED_____

BIRTHDATE: _____/_____/_____ AGE _____ □ MALE □ FEMALE

SOCIAL SECURITY #: _____

□ SINGLE □ MARRIED □ DIVORCED □ WIDOWED □ SEPARATED

HOME ADDRESS:_____

_____

HOME PHONE: _____ WORK PHONE: _____

PAGE/CAR/CELL: _____

BEST TIMES TO REACH YOU? _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

OTHER FAMILY MEMBERS SEEN BY US?: _____

EMPLOYER/SCHOOL:_____

OCCUPATION: _____

LENGTH OF EMPLOYMENT: _____ □FULL TIME □ PART TIME

EMPLOYER'S ADDRESS: _____

_____

SPOUSE/PARENT NAME:_____

BIRTHDATE: _____/_____/_____ SOCIAL SECURITY #: _____

EMPLOYER: _____

WORK PHONE: _____

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU: _____

RELATION: _____

HOME PHONE: _____ WORK PHONE: _____

HIS/HER ADDRESS: _____

_____

DO YOU HAVE A PERSONAL PHYSICIAN? □ YES □ NO

PHYSICIAN'S NAME: _____

ADDRESS: _____

_____

PHONE #: _____ DATE OF LAST VISIT: _____/_____/_____

YOUR CURRENT PHYSICAL HEALTH IS: □ GOOD □ FAIR □ POOR

WHY HAVE YOU COME TO THE DENTIST TODAY?_____

_____

ARE YOU CURRENTLY IN PAIN? □ YES □ NO

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT?
□ YES □ NO

HAVE YOU EXPERIENCED PROBLEMS WITH PREVIOUS DENTAL WORK? □ YES □ NO

DO YOU OR HAVE YOU EVER EXPERIENCED PAIN/ DISCOMFORT IN YOUR JAW JOINT (TMD/TMJ)? □ YES □ NO

YOUR CURRENT DENTAL HEALTH IS: □ GOOD □ FAIR □ POOR

DO YOU FLOSS DAILY? □ YES □ NO

BRUSH DAILY? □YES □ NO

TYPE OF BRISTLES ON YOUR TOOTH BRUSH?

□ HARD □ MEDIUM □ SOFT

HOW LONG DO YOU USE A TOOTHBRUSH BEFORE REPLACING IT?
_____

DO YOU USE ANYTHING IN ADDITION TO YOUR BRUSH AND FLOSS?
□YES □NO

IF YES, WHAT? _____

WOULD YOU LIKE FRESHER BREATH? □ YES □ NO

WHITER TEETH? □ YES □ NO

DO YOU GUMS EVER BLEED? □ YES □ NO

EVER ITCH? □ YES □ NO

HAVE YOU EVER HAD PERIODONTAL DISEASE? □ YES □ NO

DO YOU HAVE MOBILITY IN YOUR TEETH? □ YES □ NO

ARE YOU TEETH SENSITIVE TO HEAT COLD OR ANYTHING ELSE?

_____

DO YOU STILL HAVE WISDOM TEETH? □ YES □ NO

PREVIOUS DENTIST? _____

LAST VISIT DATE: _____/_____/_____

WHY DID YOU LEAVE YOUR PREVIOUS DENTIST? _____

_____

WHAT DID YOU LIKE MOST & LEAST ABOUT ANY DENTIST YOU HAVE SEEN?

_____

ARE YOU HAPPY WITH THE WAY YOUR SMILE LOOKS? □ YES □ NO

IF NOT, WHAT WOULD YOU CHANGE? _____

_____

I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THIS DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES I MAY NEED. MY METHOD OF PAYMENT WILL BE _____.

_____
SIGNATURE DATE

I CERTIFY THAT I AM COVERED BY _____ INSURANCE CO. AND I ASSIGN DIRECTLY TO DR. FIORENTINO ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AND ALSO RESPONSIBLE PAYING ANY CO-PAYMENT AND DEDUCTIBLE THAT MY INSURANCE DOES NOT COVER. I HEARBY AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS, WHETHER MANUAL OR ELECTRONIC.

_____
SIGNATURE DATE

OFFICE FINANCIAL AND INSURANCE POLICY

- Our fees are meant to be fair and reasonable. We strive to keep them that way. You help us in that effort when you pay for our services at the end of each visit. Our receptionist can tell you the approximate fee for treatment before your appointment. To make payments convenient for you at the time services are rendered: we accept cash, personal check, Visa, Master Card and Discover.

- We will cooperate fully with all our patients who are covered by insurance plans. Insured patients should read their policies carefully to become familiar with its benefits and limitations. It is important that you understand that in most cases your insurance is designed to reduce your cost, not to eliminate it completely. You are ultimately responsible for the full amount of your bill regardless of your insurance coverage.

- Patients having insurance are expected to pay any deductible and estimate of co-pay at the time of service. Any difference will be billed or refunded to you after the insurance payment has been received.

- As a courtesy to our patients, we will file your insurance claims for you. In some cases an insurance plan may pay you, the patient, directly. In such cases, we expect payment for services on the day of your visit. Any insurance payment not received after 60 days of filing becomes the responsibility of the patient. Payment from the patient is expected within 10 days of notification.

- Payment plans are available for certain procedures or any extensive treatment that has been planned and agreed to by the patient. Details will be arranged by the receptionist prior to treatment.

- Any account 90 days past will be subject to review and turned over to a collection agency unless payment arrangements are made with the office. A 25% collection fee will be added to any account turned over to our collection agency.

- Any checks returned to our office are subject to a $25 service charge fee.

- If at any time you have questions about this policy or your account, please do not hesitate to ask. We do not ever want the issues of money and insurance to come between you and the dental care you deserve.

I HAVE READ THE ABOVE POLICIES AND AGREE ALL FINANCIAL RESPONSIBILITY.

PRINTED PATIENT'S NAME

SIGNATURE OF PATIENT OR PARENT/GUARDIAN

DATE

APPOINTMENT POLICY

Our goal is to provide every patient an opportunity to receive timely and appropriate treatment. In order to do that, each patient is given a reserved appointment day and time. Emergency patients are worked into our schedule the same day as the call, if possible. We strive to have as little interruption to our schedule as possible.

We ask that all patients with scheduled appointments do two things:

1. Return confirmation phone calls. These are made as a courtesy to our patients and help ensure each appointment day and time are acceptable.
2. Provide appropriate advance notice, for routine appointments.
    a. At least 24 hours' notice, for routine appointment.
    b. At least one weeks' advance notice for patients with longer, more extensive appointments.

In order to ensure commitment to your appointments, our current policy requires a 20% deposit toward your next appointment if two consecutive appointments have been missed without advance notification. This deposit is non-refundable if the appointment is missed.

I HAVE READ AND AGREE TO ACCEPT THE TERMS OF THIS APPOINTMENT POLICY.

PRINTED PATIENT'S NAME

SIGNATURE OF PATIENT OR PARENT/GUARDIAN

DATE

VINCENT F. FIORENTINO, DDS

GENERAL DENTISTRY
21907 WESTERNPORT RD, SUITE 2 WESTERNPORT, MD 21562
(301) 786-7340 FAX (301) 786-4037

Privacy Officer: Becki Taylor **Effective Date: April 14, 2003**

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.

We care about our patient's and strive to protect the confidentiality of your medical information at this practice. New federal and state legislation requires us to maintain the privacy of your health information. We are also required to issue this official notice of 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 as of its effective date. This Notice 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 made the new Notice available upon request. The most current Notice will always be posted in our office.
You may request a copy of our Notice at any time. For more information, questions, or additional copies of this Notice, please contact our Privacy Officer.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

We use and disclose health information about you and treatment, payment and health care operations. For example:
To Provide Treatment. We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between our office staff. In addition, we may share your health information with physicians, referring dentists, clinical and between our office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies, or other health care personnel participating in providing you treatment.
To Obtain Payment. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this insurance forms filed for you through the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.
To Conduct Health Care Operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and staff performance, conducting training programs, accreditation, certification, licensing, or credentialing activities. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews.

In Patient Reminders. Communications are an important part of our philosophy in partnering with you to provide you with the best preventive and restorative dental care possible. We will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. If your appointment for treatment requires medication to be taken we will include that information at the reminder notification. Additionally, we may contact you to follow up on your care and review your planned treatment. Appointment reminders and treatment communication may come in form of postcards, letters, and telephone or voicemail messages.

Family, Friends and Caregivers. We may share your information with those you tell us will be helping you with your health care or with payment of your health care, but only if you agree that we may do so. If the case on an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information important to those involved in providing you care. We will also use our professional judgment and experience in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar health information.

Uses and Disclosures Made Without Your Consent and Authorization as Required By Law.

- public health activities, including disease and vital statistic reporting, disaster relief, and to employers regarding work-related illness or injury;
- to report a patient who is a victim of abuse, neglect, or domestic violence as we feel compelled by our ethical judgment;
- in response to court and administrative orders;
- to law enforcement officials pursuant to subpoenas and lawful processes concerning crimes, their victims, and suspects of other person;
- to coroners and medical examiners
- to the military and federal officials for lawful intelligence and national security activities;
- as authorized by state worker's compensation laws;
- to avert a serious threat to health or safety.

On Your Authorization. Other than is stated in this Notice or where Federal, State, or Local law requires us, we will not disclose your health information without your written authorization. However, at your discretion you may give us written authorization to use or disclose your health information to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time.

YOUR PATIENT RIGHTS

Access of Your Health Information. 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 in order to obtain access to your health information. You may obtain a form to request access or copies of your medical record by contacting our Privacy Officer by mail or telephone at this practice. A reasonable fee may be charged to duplicate and assemble your copy.

Restriction. You have the right to request that we place additional restrictions on our use and 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 unless an emergency prevents us otherwise. To request restrictions, you must submit your request in writing to our Privacy Officer. In your request, you must tell us what information you want to limit.

Documentation of Non-Standard Disclosures. You have the right to ask for a description of how and where your health information was used by our office for any reason other than for treatment, payment, or health care operations. To request this list, you must submit your request to our Privacy Officer. Your request must state the time period for which you want and must not be longer than two (2) years. Your request cannot include dates prior to April 14, 2003. We reserve the right to charge you for the cost of providing the list.

Alternative Communication. You have the right to request that we communicate with you by alternative means or to alternative locations. You must make your request in writing to our Privacy Officer. You must specify in your request the alternative means or location. We will make every effort to honor your reasonable requests for alternative communication.

Right To Amend. If you feel that the health information we have about you is incorrect or incomplete, you may ask to have your records updated or modified. Your request and amended information will remain in effect for as long as our office maintains this information. Your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason to support the request. We may deny your request if the information was not created by us, does not pertain to the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we determine to be accurate and complete.

Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice of Privacy Practices at any time even if you have agreed to receive this Notice electronically (e.g. e-mail).

Complaints. If you believe your privacy rights have been compromised you may express your complaint to our Privacy Officer or to the Secretary of Heath and Human Services. All complaints must be submitted in writing. We support your right to the privacy of your health information. You will not be penalized or discriminated against for filing a complaint.