Laurel Bowie Implant and Cosmetic Dentistry
Marshone E. Clark, D.D.S., P.A.
14333 Laurel Bowie Rd., Ste. #306
Laurel, Maryland 20708
301-490-5555

PATIENT INFORMATION FORM

DATE_____

NAME_____
LAST *FIRST* *MIDDLE*

ADDRESS_____
NUMBER, STREET, APT #

CITY_____**STATE**_____**ZIP CODE**_____

HOME #_____**WORK #**_____**CELL #**_____

SOCIAL SECURITY #_____**E-MAIL ADDRESS**_____

OCCUPATION_____**EMPLOYER**_____

DATE OF BIRTH_____/_____/_____**GENDER**_____**MARITAL STATUS**_____

NAME OF PARENT OR SPOUSE/PARTNER_____

EMERGENCY CONTACT PERSON_____**PHONE#**_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

MEDICAL HISTORY

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

11. When was your last dental cleaning? _____

12. Are you in good health? ……yes no

13. Has there been any change in your general health in the past year? yes no

14. Are you now under the care of physician?.....yes no

15. Have you had any serious illness, operation, or been hospitalized in the past five years?.....yes no

    If so, what was the illness or problem?_____

16. Do you have or have you had any of the following diseases or conditions?

    Damaged heart valves or **artificial heart valves** including **heart murmur** or rheumatic heart disease?.....yes no
    Cardiovascular disease? (please circle all that apply)……..…..yes no
    Heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis and stroke?
    Do you have chest pain on exertion?.....yes no
    Are you ever short of breath after mild exercise or when lying down?.....yes no
    Do your ankles swell?.....yes no
    Do you have inborn heart defects?.....yes no
    Do you have a cardiac pacemaker?.....yes no

Asthma……...yes	no		sinus trouble……...yes	no	
Fainting spells, seizures, dizziness.. yes	no		sudden weight loss……yes	no	
Diabetes…… yes	no		hepatitis……..yes	no	
AIDS or HIV infection…….. yes	no		thyroid problems……yes	no	
Respiratory problems……yes	no		artificial joints…… yes	no	
Stomach ulcer or hyperacidity……yes	no		arthritis or painful joints…... yes	no	
Tuberculosis……...yes	no		kidney trouble……yes	no	
Persistent swollen neck glands…….. yes	no		persistent cough …….yes	no	
Sexually transmitted disease…….. yes	no		low blood pressure……..yes	no	
Mental health problems……..yes	no		neurological disease……yes	no	
Immune system problems…….. yes	no		cancer/radiation treatments….yes	no	

7. Are you required to pre-medicate with antibiotics before dental treatment?.....yes no

8. Have you had abnormal bleeding?.....yes no

9. Have you ever required a blood transfusion?..... yes no

10. Do you have a history of drug or alcohol abuse?..... yes no

11. Have you ever had any treatment for a tumor or growth?..... yes no

10. Are you taking any medication(s) including non-prescription medication? yes no
If so, what medication(s) are you taking? (Please list all)

_____
_____
_____
_

11. Are you allergic or have you had a reaction to:

Local anesthetics……. yes no
Penicillin…….. yes no
Other antibiotics……...yes no
Sulfa drugs……... yes no
Barbiturates, sedatives, or sleeping pills.. yes no
Aspirin……. yes no
Latex…… yes no
Milk, egg or soy products …….... yes no
Metals……...yes no
Household bleach……yes no

List other allergies:_____
_____
_____

12. Have you had any serious trouble associated with any previous dental treatment?..... yes no

13. Do you have any diseases condition, or problem not listed above that you think the doctor should know about?..... yes no

If so, please explain_____

14. Do you have TMJ or painful clicking in the jaw?.....yes no

15. Do you smoke?..... yes no

FOR WOMEN ONLY

16. Are you pregnant?.....yes no
    If YES….How many weeks pregnant are you?_____
17. Are you nursing?.....yes no
18. Are you taking birth control pills?..... yes no

IF YES, PLEASE READ THE FOLLOWING:

I understand that certain antibiotics may render birth control medications ineffective. I understand that I will need to supplement my birth control methods during this period of time while on antibiotics, and one full menstrual cycle afterwards.

I certify that I have completed this form to the best of my knowledge and that all answers are truthful and accurate. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

SIGNATURE OF PATIENT/GUARDIAN DATE

Laurel Bowie Implant and Cosmetic Dentistry
Marshone E. Clark, D.D.S., P.A.

FINANCIAL INFORMATION

Policyholder/Person responsible for payment of bill_____

Relationship to patient_____

Name of **Dental** Insurance Company_____

Group **Name**_____Group **Number**_____

Policyholder **DOB**_____Policyholder **Social Security#**_____

A 48-hour notice is required for the cancellation of a scheduled appointment. A $150.00 cancellation fee will be charged to the patient if we do not receive notice within the appropriate time frame.

A fee of $30.00 will be charged to the patient in the event that their check is returned to us for non-payment.

I understand that Marshone E. Clark, D.D.S. is filing my insurance claim as a **courtesy.** Although this courtesy is extended to me. I understand that obtaining payment by my insurance company is ultimately my responsibility. Preauthorization by your insurance company is not a guarantee of quoted benefit. Insurance companies do not guarantee benefits until the claim is received. I also understand that I am responsible for any co-payments and/or billable charges that are **not covered** and/or denied by my insurance company. In the event payments are not received by the agreed upon dates, I understand that a 1-1 ½% finance charge (18% APR) may be added to my account, in addition to any collection charges. I understand that I will receive a bill for all outstanding charges **30** days after the date on which I received services regardless of the submitted insurance claim status.

I,_____herby authorize Marshone E. Clark,D.D.S. to apply for benefits on my behalf for services rendered to me (or my minor child) and request that payment be made By_____Insurance Company and that payment is sent directly to Marshone E. Clark, D.D.S. when warranted.

Date_____Signature (By patient or Responsible Party)_____

Marshone E. Clark, D.D.S., P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please print name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communications barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (please specify)

Marshone E. Clark, D.D.S., P.A.

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. (Note: this form may need to be changed to reflect the dental practice's particular policies and/or stricter state laws.)

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

This Notice describe 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 01/01/2004, 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 you health information or to disclose it to anyone for any purpose. If you give us 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 writing 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 to 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 $ 0.00 for each page, $0.00 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 request.

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 rights, or your 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: Marshone E. Clark, D.D.S., P.A.
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Fax: 301-490-5308
Email: marshoneclarkdds@gmail.com
Address: 14333 Laurel Bowie Road, Suite 306, Laurel, MD 20708