Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Home Phone (____)_____ Cell Phone (____)_____

Name _____ SS/HIC/Patient ID #_____
Last Name First Name Middle Initial

Address _____ E-mail_____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ ID#/Soc. Sec. # _____

Address (If different from patient's)_____ Phone (____)_____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient _____ Birthdate _____

Address (If different from patient's)_____ Phone (____)_____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____)_____

Insurance Company _____ Soc. Sec. #_____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Please Complete Both Sides

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS
List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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 may use my health care information and may disclose such information to the above-named Insurance Company(ies) 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 treatment plan is completed or one year from the date signed below.

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

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Acknowledgment Of Receipt Of Notice Of Privacy Practices

You may refuse to sign this acknowledgment

I have received a copy of Scott M. Steckler Dds, LLC's Notice of Privacy Practices.

Print Name_____

Sign_____

Date_____

For Office Use Only

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

_ Individual refused to sign

_ Communication Barriers prohibited obtaining the acknowledgment

_ An emergency situation prevented us from obtaining acknowledgment

_ Other (Please Specify)

_____

_____

_____

_____

Scott M. Steckler, DDS, LLC

Notice Of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

UNDERSTANDING YOUR HEALTH RECORD

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination and test results, diagnoses, treatment, and a plan for future care are recorded. This information is most referred to as your "health" or "medical" record, and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained is your record and how that information may be used will help you ensure its accuracy, and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

YOU HEALTH INFORMATION RIGHTS

*You have the right to inspect and copy your protected health information.

*You have the right to request a restriction of your protected health information.

*You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

*You may have the right to have your provider amend your protected health information.

*You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

*You have the right to obtain a paper copy of this notice from us.

OUR RESPONSIBILITIES

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This off ice is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate you health information by alternative means or to alternative locations.

This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file.

Other than reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

TO RECEIVE ADDITIONAL INFORMATION or TO REPORT A PROBLEM

For further explanation of this notice, you may contact our staff at (410) 267-0766.

I f you believe your privacy rights have been violated, you have the right to file a complaint with our office or with the Secretary of Health and Human Services with no fear of retaliation by this office.

USES AND DISCLOSURES Of PROTECTED HEALTH INFORMATION

Treatment - Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your of your physician recording his/her own expectations and those of others involved in providing you care, such as specialty physicians or lab technicians.

Payment - Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, or your diagnoses, procedures performed and supplies used.

Health Care Operations - The medical staff in this office will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED ON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT.

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

We will not use your health information for marketing communications without your written authorization.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION

We may use or disclose your protected health information in the following situations without your authorization:

*Required By Law

*Public Health

*Communicable Disease

*Health Oversight

*Abuse or Neglect

*Food and Drug Administration

*Legal Proceedings

*Law Enforcement

*Coroners, Funeral Directors, and Organ Donation

*Research

*Criminal Activity

*Military Activity and National Security

*Workers Compensation

*Inmates

*Health and Human Services

NOTICE OF PRIVACY PRACTICES AVAILABILITY

The terms described in this notice will be posted where registration occurs. All individuals receiving care will be given a printed copy.

Adopted Effective: April 14, 2003

Scott M. Steckler, DDS, LLC

Policy Of Payment For Dental Services

We are committed to providing you with the best possible care. If you have dental insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

As a courtesy to you, we will fill out your insurance claims. You must realize that all charges are your responsibility from the date the services are rendered. Due to the ever changing health insurance laws and regulations, we cannot guarantee that all services rendered are covered by your insurance policy. In the event that your insurance does not cover our services, you will be responsible for payment. We accept cash, checks, Visa and MasterCard. We can also assist you with applying for Care Credit Financing.

At your initial visit, you must disclose all information regarding insurance coverage that you plan to use at this office. You are also responsible for informing us of any changes to your insurance coverage. We do not work with certain insurance companies/plans. If, after treatment is initiated and any secondary policy is brought to our attention, you may have voided your right to utilize that insurance per our " no-use insurance agreement."

Charges not paid within 60 days by your insurance company will be made "patient responsibility." In the event of non-payment, you will be responsible for the cost of collections, court costs and any reasonable legal fees should these be required. Returned checks will result in a $25.00 penalty. **Account balances over 30 days past due will start to accumulate interest charges of 24% APR. This applies to all overdue account balances.**

We reserve the right to charge for appointments broken or cancelled without **48 hours** notice at a rate of **$25-$50 per half hour.**

Any procedures started, such as crowns, bridges, dentures, and root canals require the patient to return to finish treatment in a timely manner (6 weeks). If the patient fails to return to finish treatment within this time period and if the tooth fails or appliance does not fit, **no refund will be given.** Patient will be responsible for any insurance company refunds and a remake charge may be assessed.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. **We are here to help you.**
Please sign below to indicate that you have read and understand our policy of payment for dental services.

Printed patient/Guardian name Signature Date