Tuan M. Nhu, DDS

GERMANTOWN DENTAL VILLAGE

19330 Liberty Mill Road, Germantown, MD 20874
Email: drnhu@germantowndentalvillage.com
301-428-3211

PATIENT INFORMATION

Welcome to Germantown Dental Village! To assist us in serving you, please complete the following confidential forms. The information provided is important for your dental health care.

Patient's name_____Preferred name_____Birthdate_____

If minor, Guardian name_____Cell Phone_____Home Phone _____

Email: _____

Mailing address_____City_____State_____Zip_____

Employer:_____Occupation_____

Spouse's name_____Spouse's employer _____❑ Unmarried

Whom may we thank for referring you to our office? _____

Please provide an **emergency contact (Name /Phone)**: _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ I currently do not have dental benefits provider (dental insurance)

Your Social Security number:_____ Dental Insurance Co. _____

Spouse's dental insurance? ❑ yes ❑ no Dental Insurance ID _____Group # _____

Spouse's dental insurance company_____Group ID and Number _____

Spouse's birthday_____ Spouse's Social Security number _____

MEDICAL HEALTH HISTORY

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

- ❑ Cancer or tumor
- ❑ Heart attack
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism or Drug Abuse
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hay fever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you have any disease, condition, or problem not listed above?

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics: _____
- ❑ Local anesthetics
- ❑ Codeine or other narcotics:_____
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ *Other*:_____

Do you need to be PREMEDICATED for treatment? ___ Are you taking any of the following? ***Please list medications***

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners): _____
- ❑ Antibiotics or sulfa drugs: _____
- ❑ High blood pressure medicine: _____
- ❑ Antidepressants or tranquilizers: _____
- ❑ Insulin or other diabetic drug: _____
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids:_____
- ❑ Osteoporosis (bone density) medicine:_____
- ❑ ***Other medications***:_____

_____

❑ Do you smoke or use chewing tobacco? ❑ yes ❑ no

Women:

- ❑ Pregnant? ❑ yes ❑ no
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician: _____ **Phone**: _____

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Have you had dental radiographs (x-rays) taken this year? Yes / No

If you have had dental x-rays taken recently, please forward them to our office prior to your visit!

Previous Dental Provider's Office Name:_____

Phone Number of Previous Dental Office: _____

Dental Health

Do you have, or have you ever had any of the following dental conditions? Please check all that apply. *

- ☐ None of the above
- ☐ Areas of food traps
- ☐ Broken or missing teeth
- ☐ Cold sores
- ☐ Aesthetic concerns
- ☐ Jaw pain
- ☐ Jaw clenching
- ☐ Sensitive or bleeding gums
- ☐ Teeth grinding or clenching
- ☐ Dry mouth
- ☐ Gum treatments
- ☐ Swelling or lumps
- ☐ Unfavorable dental experience
- ☐ Aching or sensitive teeth
- ☐ Bad breathe
- ☐ Cavities
- ☐ Difficulty opening wide
- ☐ Facial surgery
- ☐ Gum infection
- ☐ Loose teeth
- ☐ Broken filling
- ☐ Clicking or popping jaw
- ☐ Gags easily
- ☐ Orthodontic treatment
- ☐ Growth or lesions

Are there specific dental health issues or concerns you would like to discuss?

_____

_____

_____

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 status.

Signature of patient (or Guardian): _____ **Date**: _____

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OFFICE FINANCIAL POLICY ACKNOWLEDGEMENT

Welcome to Germantown Dental Village! Thank you for choosing our practice for your dental care. We look forward to offering you and your family exceptional dental care.

Before treatment is performed, we will communicate treatment options and associate fees. This will allow you to fully understand your dental treatment needs, what to anticipate in fees, and allow you time to make the necessary financial arrangements. As such, **payment is due at the time services are rendered.**
For your convenience we accept:

- Cash
- Checks
- Visa
- MasterCard

Insurance benefits are determined by your employer, not by our dental practice. ***At no time should insurance benefits compromise your diagnosis or affect the best treatment option for you.*** Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility. Remember that dental insurance is an allowance benefit set forth by your employer. As a courtesy, we will be happy to file your claim for you to your insurance. **However, insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. Therefore, you are responsible for payment for all services rendered.**

Any deductible or estimated co-payment amount will be due at the time of treatment.

For separated or divorced parents of minors, it is our policy that the parent or guardian who accompanies the child to our office for treatment is responsible for payment of all services rendered.

APPOINTMENTS: We are committed to respecting your time! ***WE ASK THAT*** you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointments; should you need to reschedule your appointment,

WE REQUIRE NOTICE OF AT LEAST 48 HOURS IN ADVANCE.

FOR BROKEN OR MISSED APPOINTMENTS, A FEE OF $100 DOLLARS WILL BE CHARGED PER APPOINTMENT. ANY MISSED APPOINTMENTS OF 2 HOURS OR MORE WILL INCUR A CHARGE OF $150 DOLLARS PER APPOINTMENT.

Additionally, there is a $30.00 processing charge for **non-sufficient funds** or returned checks.

Payment plans and financial arrangements are available for comprehensive dental treatment. Please speak to us to make arrangements prior to commencing treatment.

I, _____, have read and understand these financial terms and appointment policies.

Signature _____ Date_____

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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.

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 April 14, 2003, 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 your health information or to disclose it to anyone for any purpose. If you give us an 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 written 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 of 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.

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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 $0.50 for each page, $15 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 requests.

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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you 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: Tuan Nhu, DDS Phone: 301-428-3211 Address: 19330 liberty mill rd, Germantown, MD 20874

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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.

Signature: _____

Date: _____

**************************ONLY Sign here if you do not consent to HIPAA**************************

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you receive this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Name: _____

Signature: _____

Date: _____