Ronan Freyne, DMD
5530 Wisconsin Avenue, Suite 1030
Chevy Chase, Maryland 20815

PATIENT INFORMATION

_____

Last First Middle

How do you wish to be addressed? _____

Address

_____

_____

City State Zip

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Preferred method of contact (circle) home phone / cell phone / email

Social Security # _____ Date of Birth _____

Marital Status: ____ single ____ married ____widowed ____divorced Sex: ___M ___F

Are any family members with us? **Y or N** Who? _____

Whom may we thank for referring you? _____

Employer/Occupation _____

Emergency Contact/Relationship/Phone # _____

INSURANCE & BILLING INFORMATION

We provide the courtesy of filing your insurance claims on your behalf. Please provide us with your Insurance ID card at time of registration.

Person responsible for account/relation to patient _____

Date of Birth/Social Security # _____

Dental insurance company _____

Employer name and address _____

_____

Group # _____ Insurance ID # _____

DENTAL HISTORY

Reason for today's visit _____

Have you had any orthodontic work? **Y or N** **Do** you clench or grind your teeth? **Y or N**

Do you wear sports, night guard or retainer? **Y or N** Have you had any head, neck or jaw injuries? **Y or N**

Do you have frequent headaches? **Y or N** Do you have any sores or lumps in or near your mouth? **Y or N**

Are your teeth sensitive to hot or cold liquids/foods? **Y or N** Sweet or Sour liquids/foods? **Y or N**

Former Dentist _____

Date of your last dental visit _____ Were X-rays taken? _____

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

Do your gums bleed while brushing or flossing? **Y or N** Do you clench or bite your cheeks frequently? **Y or N**

Do you feel pain in any of your teeth? **Y or N** Are you pleased with the appearance of your smile? **Y or N**

MEDICAL HISTORY (CONFIDENTIAL)

Physicians Name _____ Date of last visit _____

Have you had any serious illnesses or operations? **Y or N** If yes, please describe with dates

_____

Have you ever had a blood transfusion? **Y or N** If yes, the approximate date _____
Women: Are you pregnant? **Y or N** Taking birth control pills? **Y or N** Nursing? **Y or N**
Do you use tobacco? **Y or N** Do you drink alcohol? **Y or N**
Do you use medical marijuana or other recreational drugs? **Y or N** Are you wearing contact lenses? **Y or N**
Check if you have or have had any of the following:

___ AIDS/HIV Pos.
___ Anemia
___ Arthritis, Rheumatism
___ Artificial Heart Valve
___ Asthma
___ Back Problems
___ Blood Disease
___ Cancer
___ Hemophilia
___ Hypertension
___ Hepatitis A/B/Other
___ Rheumatic Fever
___ Cough up blood
___ Diabetes
___ Epilepsy
___ Fainting
___ Glaucoma
___ Headaches
___ Heart Problems
___ Heart Murmur
___ Psychiatric Care
___ Radiation Treatment
___ Respiratory Disease
___ Jaw Pain
___ Kidney Disease
___ Liver Disease
___ Low Blood Pressure
___ Mitral Valve Prolapse
___ Nervous
___ Pacemaker
___ Tobacco Habit
___ Tuberculosis
___ Ulcer
___ Cough, persistent
___ Scarlet Fever
___ Sexually transmitted disease
___ Shortness of breath
___ Skin Rash
___ Stroke
___ Swelling of feet/ankles
___ Thyroid Problems
___ Chemical Dependenc
___ Circulatory Problems
___ Cortisone Treatments
___ Hypertension

MEDICATIONS

List any medications you are currently taking _____

_____

Is there anything else we should know about your health that we have not covered? _____

_____

Do you have any disease, condition or problems not listed? If so, please explain _____

_____

Would you like to speak to the doctor privately about any problem? **Y or N**

ALLERGIES

___ Aspirin ___ Penicillin ___ Latex ___ Other
___ Codeine ___ Sulfa ___ Local Anesthetic

PLEASE READ AND INITIAL THE FOLLOWING

___ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
___ I understand that a fee may be charged for broken appointments as well as an appointment cancelled with less than 48 hours notice.
___ I authorize the release of any information concerning my healthcare, advice and treatment to another dentist and/or Insurance company to secure payment of benefits.
___ I understand that all professional services are charged directly to the patient and that I am responsible for payment of fees including all collection/attorney fees.

_____

Patient/Responsible Party Signature Date

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in completing this form.

_____ _____

Patients/Responsible Party Signature Date Doctors Signature Date

Dr. Ronan Freyne

Smile Evaluation Form

Are you happy with the appearance of your teeth/gums/smile?
☐ Yes ☐ No

Would you like to discuss enhancing the appearance of your smile? ☐ Yes ☐ No

What don't you like about your smile? (color, shape, alignment, wear, etc)_____

Would you like to discuss how to make your teeth WHITE?
☐ Yes ☐ No

OFFICE POLICY STATEMENTS

Payment is due at the time treatment. We accept cash, check and major credit cards. We also offer a flexible payment plan on major series, which may allow you to start your treatment and spread payments over a two-three month period.

- There is a $30 fee charged on returned checks Initial_____

We require your services to be paid at the time of treatment and we will also happily file your insurance claims. We require you to present all of your insurance information, as well as a copy of your insurance card. Please remember your insurance policy is contract between you and your insurance company. We expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including pre-authorizations and authorization requirements. We will, however, assist you to ensure that all plan requirements are met.

Initial _____

Our office requires more than 48 "BUSINESS" hours notice to cancel an appointment. If there is less than 48 hours notice of cancellation there will be a $95 fee. The aforementioned fees also apply to missed or broken appointments. Your cooperation in cancelling your schedule appointment well in advance allows us the opportunity to offer your appointment to a person who needs dental care.

Initial _____

It is imperative for you to arrive on time for your appointments. Please understand that the doctor's time is just as valuable as your time, and that the most common reason our office runs behind is due to patients arriving late for their appointments. If you are more than twenty minutes late for your appointment the doctor may not be able to see you and your appointment will be rescheduled for another day and time.

Initial _____

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us, in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you the patient, significant new rights to understand and control how your health information is used. HIPPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose you're your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations included in the business aspects of running out practice such as conducting quality assessment and improvement activities, auditing functions cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by representing a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information form us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Office of

RONAN FREYNE, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

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

_____

Name Printed

_____

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

____ Communication barrier prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other

_____