OASIS DENTAL
602 S. ATWOOD RD
SUITE 101C
BEL AIR, MD 21014
(410) 776-3168

PATIENT REGISTRATION FORM

Section I — Patient Information

Name:_____ I Prefer to be called: _____

Address:_____City:_____State:_____Zip:_____

Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____)_____

Email Address: _____

Date of Birth: _____ ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Sex: ☐ Male ☐ Female

Name of Employer or School: _____ City/State: _____ ☐ FT ☐ PT

Spouse or Parent's Name: _____ Employer: _____ Work Phone: (____) _____

Whom may we thank for referring you? _____

Emergency contact: _____Relationship: _____Phone: (_____) _____

Section II — Responsible Party

Relationship to Patient: ☐ Self (if self, you don't need to complete this section) ☐ Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Employer: _____ Work Phone: (____)_____

Section III — Dental Insurance Information

Name of Insured: _____ DOB: _____Relationship to Patient _____

Name of Employer: _____Insurance Company: _____

Grp #_____ ID# OR SSN#_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? IF YES, COMPLETE THE FOLLOWING

Name of Insured: _____DOB: _____ Relationship to Patient: _____

Name of Employer: _____ Insurance Company: _____

Grp # _____ ID# OR SSN # _____

HEALTH HISTORY

DENTAL INFORMATION:

What made you schedule this dental appointment? _____

Previous Dentist: _____
How often do you brush? _____
Dry Mouth? _____
Mouth odor/bad taste? _____
Tooth Sensitivity (hot/cold sweets or pressure)? _____
Loose Teeth? _____
History of periodontal (gum) disease? _____

Last Dental visit? _____ Last Dental Cleaning? _____
How often do you floss? _____
Broken Teeth? _____
Clenching/grinding? _____
Sore or bleeding gums? _____
Difficulty chewing? _____
Temporomandibular disorders (TMJ)? _____

ARE YOU NERVOUS ABOUT DENTAL TREATMENT? _____

MEDICAL INFORMATION:

Do you require pre-medication for dental treatment? _____ Reason: _____ Type: _____

Please list any allergies to medications: _____ _____

_____ _____ _____

_____ _____ _____

Please list any other allergies: _____ _____ _____

_____ _____ _____ _____

Are you or have you ever been a tobacco user? _____ If so, how many years? _____ how often? _____ Quit date: _____

Drug or alcohol dependency: _____Type: _____ In recovery? _____

MEDICAL CONDITIONS REQUIRING MEDICATION/TREATMENT:

Condition: _____ Medication/dose/freq: _____
Condition: _____ Medication/dose/freq: _____
Condition: _____ Medication/dose/freq: _____
Condition: _____ Medication/dose/freq: _____
Condition: _____ Medication/dose/freq: _____
Condition: _____ Medication/dose/freq: _____
Condition: _____ Medication/dose/freq: _____
Condition: _____ Medication/dose/freq: _____

(if additional space is needed- please attach list)

ADDITIONAL MEDICAL CONDITIONS (NOT REQUIRING MEDICATION OR TREATMENT)

_____ _____ _____

_____ _____ _____

DATE: _____ SIGNATURE: _____

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OFFICE POLICIES

Appointments

Please understand that arriving late for your scheduled appointment time may result in the rescheduling of your appointment. We do ask for one business day notice (M-F) to reschedule or cancel an appointment. The charge for lack of notice will result in a missed appointment fee. **Dr. Gherman reserves the right to dismiss a patient from the practice if a patient has repeated broken or missed appointments.**

Financial Agreement

Whenever possible, an estimate of out-of-pocket cost will be provided prior to treatment. All estimated out of pocket costs are due at the time of service. We accept all major credit cards, check and cash payments.

Extended Payments: *CareCredit offers no interest plans to make dental care affordable. This plan provides up to 12 months deferred interest, if paid within the promotional period. Otherwise, interest is assessed from the purchase date. A minimum payment is required. CareCredit is subject to credit approval. Please ask any of our staff members for additional information, a brochure or application if interested.*

Collection Fees: *A $30 fee will be charged for all returned checks. Accounts with balances over 30 days will be subject to late fees in the amount of 2% on a monthly basis. All accounts with balances of 90 days will be turned over to Collections and subject to additional fees for the collection services. For all patients under the age of 18, the legal guardian presenting the patient for treatment is responsible for all payments to Oasis Dental.*

Authorization and Consent

I agree that I have filled out these forms with the intent of honesty and I agree that it is my own responsibility to update any changes in my medical history and or conditions with each dental visit.

Release of Information: I authorize Oasis Dental to release any information regarding my dental/medical history, diagnosis, or treatment to third party payers and/or other health professionals.

Assignment of Insurance Benefits: I authorize and request my insurance company to pay my benefits directly to Oasis Dental.

Photography Release: I authorize Oasis Dental to take photographs of me to help me better understand my current dental condition and possible treatment options.

Receipt of Privacy Policies: Our privacy policies are now online and can be downloaded and printed from our website (https://oasisdentalmd.com/sites/default/files/forms/privacy_notices_2021.pdf)

Dental Insurance

To avoid disappointments, we expect our patients to contact their insurance company to be sure of their dental benefits. Dental plans can change from year to year. **It is important to let us know in advance of any planned appointments if your dental plan or dental benefits have changed.** We do our best to obtain the most accurate information from your insurance company but is it ultimately the patient's responsibility to know and understand their dental insurance benefits.

As a courtesy, we will file your insurance, speak on your behalf to the insurance company and accept any assignment of benefits that your insurance company will allow. We will estimate your patient portion by considering the information provided by your insurance company. The insurance company will not guarantee payment; therefore, all patients are directly responsible for all charges.

Deductibles and estimated co-payment are due at the time services are rendered. If we do not receive payment from your insurance carrier within a reasonable time frame (typically 60 days), you may be responsible for payment in full of your treatment fees and you can collect reimbursement directly from your insurance carrier. For those patients whose insurance pays them directly, payment in full is due at the time of service.

If at any time you have questions regarding treatment, fees, or services, please discuss them with us.

General Informed Consent

I consent to be a patient at Oasis Dental and agree to a radiographic and clinical examination.

I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time, and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____

Patient Name (Please Print)

_____ _____

Patient, Parent or Guardian Signature ***Date***

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HIPAA Representative Form

THIS FORM NEEDS TO BE COMPLETED IF YOU WISH TO ALLOW ACCESS TO YOUR PERSONAL HEALTH INFORMATION. (THIS INCLUDES BUT IS NOT LIMITED TO SPOUSES, PARENTS, AND OTHER FAMILY MEMBERS). YOU MAY DECLINE SELECTING A HIPAA REPRESENTATIVE.

Patient Information – Please Print : Patient Name:_____DOB:____/____/____

_____**I decline to select a HIPAA Representative.**
(please sign at the bottom of this page.)

_____**I wish to select a HIPAA Representative.**
(please complete all information below)

I understand that by voluntarily signing this form I am identifying, authorizing, and granting permission to the HIPAA Representative named below to have authority to access to my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below:

HIPAA Representative Information: Please Print:

Name:_____ DOB:____/_____/_____ Relationship:_____

Address:_____ Phone: _____

Name:_____ DOB:____/_____/_____ Relationship:_____

Address:_____ Phone: _____

Name:_____ DOB:____/_____/_____ Relationship:_____

Address:_____ Phone: _____

I grant to the HIPAA Representative named above access to:

___ All of my personal health information- note separate box below is also required for HIV, psychiatric and substance abuse access.

___ Other- Specify Limits or specific health care incident_____

By checking the appropriate categories and by signing this box I (patient) am granting my HIPAA Representative access to additional health information:

I understand that this health information may include HIV- related information and /or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this box, I am specifically authorizing my HIPAA Representee access to information relating to:

____ Substance Abuse (including alcohol/drug abuse)
____ Mental health
____ Psychotherapy Notes
____ HIV related information (including AIDS related testing)

This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Signature of Patient for this box: _____ Date: _____

1. I understand that I may revoke this HIPAA Representative designation at any time by notifying Oasis Dental in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Oasis Dental prior to their receipt of the revocation.

2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.

3. I understand that information disclosed pursuant to this form may be redisclosed by the recipient and no longer protected by HIPAA.

4. I understand that this Authorization will be effective for the lifetime of the patient unless revoked (see #1 above)

Signature of Patient: _____ Date: _____
(Form will not be valid unless all appropriate blanks are filled)