White Marsh Family Dentistry

TMJ & MIGRAINE SOLUTIONS

11600 Crossroads Circle – Suite A
Baltimore, MD 21220
410-931-7133

Thank you for choosing White Marsh Family Dentistry as your health care office. We realize that selecting a dental office for your care is not easy and hope your experience here will allay any concerns you have. Our goal is not only to provide you with a level of comprehensive care very few offices offer but to also help you understand the information that is provided to you. The result of our commitment ensures that you will be empowered to make educated and informed decisions regarding your health care thereby achieving long lasting function, stability and better health.

Doctors John A. Farrugia and Steven R. Litwin
And all of us at White Marsh Family Dentistry

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/21/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

Prevent or control disease, injury or disability;
Report child abuse or neglect;
Report reactions to medications or problems with products or devices;
Notify a person of a recall, repair, or replacement of products or devices;
Notify a person who may have been exposed to a disease or condition; or
Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 the U.S. Department of Health and Human Services

Privacy Official: Pam Tonarella
Telephone: 410-931-7133 Fax: 443-455-1490
Address: 11600 Crossroads Circle Ste A. Baltimore, Maryland 21220
Email: info@whitemarshdental.com

WHITE MARSH FAMILY DENTISTRY

11600 Crossroads Circle – Suite A
Baltimore, MD
410-931-7133

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

Name _____ SS # _____ - _____ - _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Phone: (h) _____ - _____ - _____

Sex ( ) M ( ) F Birthdate _____ ( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone _____ - _____ - _____

* Email _____ Cell Phone _____ - _____ - _____
* allows you to access your account online and receive automated appointments and reminders

Whom may we thank for referring you? _____

Notify in case of emergency _____ Phone: (h) _____ - _____ - _____ (c) _____ - _____ - _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ SS# _____ - _____ - _____

Address (if different from Patient) _____ Phone: (h) _____ - _____ - _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____ - _____ - _____

Insurance Company _____ Phone _____ - _____ - _____

Contact # _____ Group # _____ Subscriber # _____

Name of other dependants under this plan _____

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

Finance charge: If I do not pay the entire new balance with 25 days of the monthly billing date, a Finance Charge will be added to the account for the current monthly billing period. The Finance Charge will be a periodic rate of 2.0% per month (or a minimum charge of $2.00 for a balance under $100.00) which is an ANNUAL PERCENTAGE RATE OF 24% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

_____ Date: _____
Signature of Responsible Party

Dental History

What would you like us to do today? _____ Are you in dental discomfort today ? _____

Date of last dental care and reason for visit _____ Date of last X-rays _____

Mark the boxes below if you have had problems with any of the following:

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

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____ - _____ - _____

Date of last visit _____ Reason _____ Have you had any serious illness or operations? ☐ Y ☐ N

If yes, describe _____

Are you currently under physician's care? ☐ Y ☐ N If yes, describe _____

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate date(s) _____

Women: Are you pregnant? ☐ Y ☐ N Nursing ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check if you have had any of the following:

- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Rheumatic/Scarlet Fever
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Back Problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough up blood
- ☐ AIDS/HIV positive
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems describe _____
- ☐ Hemophilia /abnormal bleeding
- ☐ Herpes
- ☐ High blood pressure
- ☐ Cough persistent
- ☐ Jaw pain
- ☐ Kidney disease or malfunction
- ☐ Liver disease
- ☐ Material allergies (latex wood, metal, chemicals)
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker/Heart surgery
- ☐ Psychiatric care
- ☐ Rapid weight gain or loss
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Shingles
- ☐ Hepatitis
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Spine bifida
- ☐ Stroke
- ☐ Surgical implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease or malfunction
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer/Colitis
- ☐ Venereal disease

List any medications you are currently taking:

_____

_____

List any drug allergies:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that his information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change to my medical status I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date: _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT

_____ _____

Hyg initial **DDS initial**

WHITE MARSH FAMILY DENTISTRY

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* You May Refuse to Sign This Acknowledgment*

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

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)

Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height _____ age _____

weight _____ male/female _____

category 1

2. Do you snore?

- ☐ yes
- ☐ no
- ☐ don't know

If you snore:

3. Your snoring is?

- ☐ slighly louder than breathing
- ☐ as loud as talking
- ☐ louder than talking
- ☐ very loud. Can be heard in adjacent rooms

4. How often do you snore?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

5. Has your snoring ever bothered other people?

- ☐ yes
- ☐ no

6. Has anyone noticed that you quit breathing during your sleep?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

category 2

7. How often do you feel tired or fatigued after your sleep?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?

- ☐ yes
- ☐ no

If yes, how often does it occur?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

category 3

10. Do you have high blood pressure?

- ☐ yes
- ☐ no
- ☐ don't know

(For office use)

Scoring Questions: Any answer within the box outline is a positive response

Scoring categories:

Category 1 is positive with 2 or more positive responses to questions 2-6 ☐

Category 2 is positive with 2 or more positive responses to questions 7-9 ☐

Category 3 is positive with 1 positive response and/or a BMI>30 ☐ (BMI = Body Mass Index)

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

Patient Signature _____ Date _____