Lifetime Smile
ESTHETIC & RESTORATIVE DENTISTRY
Expert care coupled with personalized service.

Today's date :

Patient Registration Form

Last name: **First name:** **M.I:** **Birth date: / /**

If Patient is Minor Guardian First & Last Name: **Birth date / /**

Address: **City:**

State: **Zip code:** **Male[ ] Female[ ] Single [ ] Married:[ ] Widowed[ ]**

Home Phone No.: **Cell No.:** **Work No. :**

Social Security Number: **Email for confirmation:**

Insurance Information

Insurance Company: **Insurance address:**

Policy holder name: **Policy holder SSN:**

Policy holder DOB: / / **Patient DOB: / /**

Policy holder employer name: **Group No.:**

Subscriber ID:

Do you have secondary Insurance?

Person Financially Responsible for the Account

Name: **Relationship to the patient :** **SSN:**

Date of birth / / **Address: (if different from Patient)**

Email address: **Cell No. :** **Work No.:**

Getting to know you

Is another member of your family or relative a patient at our office?

Referred to us by [ ] Patient Name **Clipper [ ] Practice Website [ ] Insurance website [ ] Other [ ]**

Person to contact for Emergency : **Phone No.:**

What are your preferred appointment times?: **Morning: _____ Afternoon_____**

Monday_____Tuesday_____Wednesday_____Thursday_____Friday_____

Lifetime Smile™
ESTHETIC & RESTORATIVE DENTISTRY

Concerning Insurance

We are participating dentists for many insurance plans. The patient is responsible for following the proper guidelines established by his/her insurance carrier.

Patients covered by dental insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. As a courtesy to you, we will file your claims with your insurance carrier at the time of service. You will be billed your insurance copayment amount and deductible at the time that the services are rendered based on an estimate of coverage provided by your insurance carrier. If there are any additional charges that are not covered by insurance, you will be billed accordingly.

The insurance coverage information given by staff is only an estimate based on the information provided by your insurance company. This does not guarantee coverage or inform us of any limitations or exclusions in your plan. Please read the booklet provided by your insurance company for these. All insurance payment estimates are based upon the information given to us by you and the insurance company.

I understand this is an estimate and my insurance may or may not provide coverage. _____(initial)

I also understand any balance remaining will be my responsibility _____(initial)

Even though than an insurance claim is filed, you will receive a statement each month if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. We will contact your insurance carrier if we have not received payment; however, any balance outstanding after 60 days is your responsibility.

Authorization to release and assign insurance benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in the place of the original assignment. I hereby assign Dr. Ranju Bhasin and Dr. Viviana P. Urban D.D.S. for any services furnished to me or my dependents by that provider. This authorization is in effect for all future claims, until I choose to revoke it.

Patient Signature_____ Date_____

If Minor Guardian Signature_____ Relationship to Patient_____ Date_____

Lifetime Smile™
ESTHETIC & RESTORATIVE DENTISTRY

Consent for Treatment

1. I authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Bhasin and Dr. Urban to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a compete recital of any possible complications.
4. Lastly, I agree to be responsible for payment on my behalf or my dependents. I understand that if I provide incorrect or expired insurance information, I will assume full financial responsibility for all charges incurred. I understand if that my co-pay is not paid at the time of service or if there is a balance due after insurance and I have been billed this balance, there will be a $15 repeat billing fee for every month the balance is not paid. I understand that the payment is due at the time of services unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. I understand that there will be a $35 fee for returned checks.
5. I understand that I am responsible for any additional charges incurred if my account goes to collection.
6. I understand there is a broken appointment fee based on time reserved if I fail to notify the office within 48 business hours of a scheduled appointment. I understand this cancellation notice is necessary to provide the office staff sufficient time to give the appointment time to another patient. Voicemail notifications left over the weekend do not meet the advanced notification requirement for Monday appointments. The fee for late cancellation or missed dental appointments is $50 per hour reserved which must be paid before the next appointment can be scheduled.

   By my signature, I certify that the information provided on my patient registration form and regarding my insurance coverage is correct and acknowledge that I have read and understand the above consent, financial, and cancellation policies.

   Patient signature: _____ Date _____Witness _____

   Or Responsible Party Signature _____ Relationship to Patient _____Date_____

Photography Release

I, _____ consent to agree for intra-oral images of my mouth to be shared with other professionals or patients to educate and explain dental procedures and possible results of treatment.

Patient signature _____ Date_____

Medical History

Patient Name _____ Medical Alert: _____

In order to serve you better, please answer the following questions:
Physician's name: _____Phone Number _____
Have you had any medical care in the past two years? _____
Describe_____

1. Have you taken any medication, drugs, pills or herbal remedies including regular dosages of aspirin? Yes No
2. Are you currently taking any medication, drugs, pills or herbal remedies, including aspirin? Yes No
   If yes, please list name and dosage:_____
3. Have you ever taken prescription medications for weight loss (diet pills)? Yes No
   If yes, did you take any of the following? Fen-Phen ☐ Pondimen ☐ Redux ☐ Other_____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or similar drugs Yes No
5. Are you aware of having **an allergic** (or adverse) reaction to any substance or medication? Yes No
   If yes, please specify:_____
6. Have you been a patient in the hospital during the past five years? _____
7. Indicate which of the following you have had, or have at present. **Mark "yes" or "no" individually to each item**

Heart (Surgery, Disease, Attack)	Yes No	Ulcers	Yes No
Hepatitis A B C (circle)	Yes No	Chest pain	Yes No
Diabetes	Yes No	Venereal Disease	Yes No
Congenital Heart Disease	Yes No	Thyroid problems	Yes No
A.I.D.S/H.I.V Positive (circle)	Yes No	Heart Murmur	Yes No
Glaucoma	Yes No	Cold Sores/Fever Blisters	Yes No
High/Low Blood Pressure	Yes No	Contact Lenses	Yes No
Blood Transfusion	Yes No	Mitral Valve Prolapse	Yes No
Emphysema	Yes No	Hemophilia	Yes No
Artificial Heart Valve/Pacemaker	Yes No	Chronic Cough	Yes No
Sickle Cell Disease	Yes No	Rheumatic Fever	Yes No
Tuberculosis	Yes No	Bruise Easily	Yes No
Arthritis/Rheumatism	Yes No	Asthma	Yes No
Liver Disease/Jaundice	Yes No	Cortisone Medicine	Yes No
Hay fever/Allergy/Hives	Yes No	Neurological Disorders	Yes No
Swollen Ankles	Yes No	Latex Sensitivity	Yes No
Epilepsy or Seizures	Yes No	Stroke	Yes No
Sinus Trouble	Yes No	Fainting or Dizzy Spell	Yes No
Diet (Special/Restricted)	Yes No	Radiation Therapy	Yes No
Nervous/Anxious	Yes No	Artificial Joints (hip, knee. etc.)	Yes No
Chemotherapy	Yes No	Psychiatric/ Psychological Care	Yes No
Kidney Trouble	Yes No	Tumors	Yes No

8. Have you lost or gained more than 10 pounds in the past year? _____
9. Do you have or have you had any disease, condition, or problem not listed Yes No
   If yes, please list_____
10. **Women:** Are you pregnant or think you could be pregnant? Yes Months ___ No **Nursing?** Yes No
11. Do you use birth control medications? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature_____ Date_____

History Review: *For Office Docotor's Use Only*

Dentist Signature:_____ Date:_____

Dental History

Patient Name:_____

What is the reason for your visit today? _____

Date of Last Dental visit_____ **Last Dental Cleaning**_____**Last Full Mouth X-rays**_____

What was done at your last dental visit _____

Previous Dentist Name _____Phone Number_____
How often do you have dental examinations? _____ How often do you brush your teeth?_____ floss?_____
Have you ever used or are you currently using topical fluoride? Yes No
What other dental aids do you use? (Interplak, toothpick, etc.) _____
Do you have any dental problems now? Yes No
If yes, please describe_____

Please circle the Yes or the No to the questions below:

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Biting or chewing?	Yes	No
Sweets	Yes	No

Gums:

Have you noticed any mouth odors or bad tastes?	Yes	No
Have your parents experienced gum disease?	Yes	No
Or tooth loss?	Yes	No
Do you frequently get cold sores, blisters?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes where? _____

Have you ever had:

Orthodontic treatment?	Yes	No	Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No	Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No	A serious injury to the mouth or head?	Yes	No

If you have had a serious injury to your mouth or head, please describe, including the cause_____
_____

Have you experienced:

Clicking or popping of the jaw	Yes	No	Pain? (Joint, ear, side of face)	Yes	No
Difficulty in opening or closing	Yes	No	Difficulty in chewing on either side of the mouth?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No	Headaches, neckaches or shoulder aches?	Yes	No

Do you?

Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No
Clench or grind your teeth while awake or asleep	Yes	No

Are you satisfied with your teeth's appearance? _____

Would you like to keep all your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern? _____		
Have you ever had an upsetting dental experience?	Yes	No
If yes, please describe_____		
Have you ever been told to take pre-medication prior dental treatment	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No
If yes, please describe_____		

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
RANJU BHASIN, DDS, LLC - LIFETIME SMILE

SECTION A: PATIENT GIVING CONSENT

Name(s): _____ Social Security #:_____

Address: _____

Telephone: _____E-mail:_____

If there are other persons you wish us to disclose your personal health information to please list them below. This includes, but is not limited to, spouses, parents, children, and any other person(s). Without the patient's consent we will not disclose **ANY** health information to any unauthorized person regardless of the relation to the patient.

1._____
Full Name Relationship
2._____
Full Name Relationship

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Ranju Bhasin, DDS
Telephone: 301-869-1170 Fax: 301-869-0569
E-mail: urbandds@comcast.net
Address: 101 Lakeforest Blvd. 101B, Gaithersburg, MD 20877

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

NOTICE OF PRIVACY PRACTICES

LIFETIME SMILE - DR. RANJU BHASIN

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. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you.

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 dentist or other healthcare provider providing treatment to you for: a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This may include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include things such as 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.

Marketing Health Products or Services: We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without your prior authorization.

To You, 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 or, if you are not able to agree, if it is necessary in our professional judgment.

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.

Required by Law: We may use or disclose your health information when we are required to do so by law, including judicial and administrative proceedings.

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.

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 and Treatment Alternatives: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to review 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 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. [Need to discuss; state law dependent]

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, where you have provided an authorization and certain other activities, for the last 6 years, but not for disclosure made prior to April14, 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 in writing that we communicate with you about your health information by alternative means or to alternative locations. 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.

Electronic Notice: If you receive this Notice on our a Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints:

If you want more information about our privacy policies or have concerns, please contact us. If you are concerned that we 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 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 Officer: Ranju Bhasin, D.D.S.

Telephone: 301-869-1170

Fax: 301-869-0569

E-mail: urbandds@comcast.net

Address: 101 Lakeforest Blvd. 101B, Gaithersburg, Md. 20877

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the notice of privacy practices of Ranju Bhasin, DDS, LLC.

_____

Please Print Name(s) (A parent or guardian may list children on same form)

_____

Signature (If under 18 a parent or legal guardian must sign all forms)

Date_____

OFFICE USE

[ ]Individual Refused to Sign [ ] Communication Barrier prohibited obtaining acknowledgement
[ ] Emergency Situation prevented us from obtaining signature
[ ]Other
specify_____