**Drs. Meson and Azoulay**
**8383 Cherry Lane**
**Laurel, Maryland 20707**
**301-498-5320**

## PATIENT INFORMATION

Patient's Last Name_____ Patient's First Name _____Male or Female

Address_____City_____

State_____ Zip Code_____ Date of Birth_____ SS#_____-_____-_____

Home #_____Cell Phone #_____Work #_____

**Email address**_____

Employer_____ Occupation_____

Drivers License#_____ State_____

How did you hear about our office?_____

**Person to contact in case of emergency**_____ Telephone #_____

**Parent information if patient is a minor**:

Parent's Last Name_____ Parent's First Name_____

Employer _____Occupation_____

Work #_____Drivers License #_____ SS#_____

## INSURANCE INFORMATION

Primary Insurance Company_____ ID#_____ Group #_____

Insurance Company Address _____Phone #_____

Subscriber Name_____ Date of Birth_____ SS#_____

Employer of Subscriber_____ Phone # of Subscriber_____

Subscriber Relationship to Patient Self _____ Spouse _____ Parent _____ Child _____

**Physician Name**_____ **Phone #**_____

**Pharmacy Name**_____ **Phone #**_____

| Y | N | Conditions |
|---|---|---|
| ☐ | ☐ | Abnormal bleeding |
| ☐ | ☐ | Alcohol Abuse |
| ☐ | ☐ | Allergies |
| ☐ | ☐ | Anemia |
| ☐ | ☐ | Angina Pectoris |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Artificial Heart Valve |
| ☐ | ☐ | Artificial Joints |
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Blood Transfusion |
| ☐ | ☐ | Cancer-Chemotherapy |
| ☐ | ☐ | Colitis |
| ☐ | ☐ | Congenital Heart Defect |
| ☐ | ☐ | Cosmetic Surgery |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Difficulty Breathing |
| ☐ | ☐ | Drug Abuse |
| ☐ | ☐ | Emphysema |
| ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Fainting Spells |
| ☐ | ☐ | Fever Blisters |
| ☐ | ☐ | Frequent Headaches |

| Y | N | Conditions |
|---|---|---|
| ☐ | ☐ | Glaucoma |
| ☐ | ☐ | HIV+ AIDS |
| ☐ | ☐ | Hay Fever |
| ☐ | ☐ | Heart Condition |
| ☐ | ☐ | Heart Surgery |
| ☐ | ☐ | Hemophilia |
| ☐ | ☐ | Hepatitis |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Kidney Problems |
| ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Low Blood Pressure |
| ☐ | ☐ | Mitral Valve Prolapse |
| ☐ | ☐ | Pace Maker |
| ☐ | ☐ | Psychiatric Problems |
| ☐ | ☐ | Radiation Therapy |
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Shingles |
| ☐ | ☐ | Sickle Cell Disease |
| ☐ | ☐ | Sinus Problems |
| ☐ | ☐ | Sleep Apnea |
| ☐ | ☐ | Stroke |
| ☐ | ☐ | Thyroid Problems |

| Y | N | Conditions |
|---|---|---|
| ☐ | ☐ | Transplant Surgeries |
| ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Ulcers |
| ☐ | ☐ | Venereal Disease |
| ☐ | ☐ | Yellow Jaundice |

| Y | N | Allergies |
|---|---|---|
| ☐ | ☐ | Aspirin |
| ☐ | ☐ | Codeine |
| ☐ | ☐ | Dental Anesthetics |
| ☐ | ☐ | Erythromycin |
| ☐ | ☐ | Jewelry |
| ☐ | ☐ | Latex |
| ☐ | ☐ | Metals |
| ☐ | ☐ | Penicillin |
| ☐ | ☐ | Tetracycline |

Other:

_____

_____

**Please answer the following**:

| Y | N | |
|---|---|---|
| ☐ | ☐ | Do you smoke or use tobacco? |

Height _____

Weight_____

**If female, please answer the following:**

| Y | N | |
|---|---|---|
| ☐ | ☐ | Are you taking Birth Control Pills? |
| ☐ | ☐ | Are you pregnant? If yes, # of weeks ____ |
| ☐ | ☐ | Are you nursing? |

**Medications: Please list all**

| Y | N | |
|---|---|---|
| ☐ | ☐ | **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below** |

_____ _____

**Signature** **Date**

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Thank you for choosing our office. We are committed to providing you with the best possible care. If you have any questions regarding fees for treatment, please feel free to discuss them with us. We will make every effort to avoid misunderstandings and preserve our relationship.

Payment for services is due at the time treatment is rendered. If you have dental insurance, we are anxious to help you receive maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policies. We will be happy to process your **primary** insurance claims for reimbursement as well as accept insurance assignment. We will gladly discuss your proposed treatment and answer general questions relating to your insurance. Our office is provided with "general benefit" information from your insurance, which is not specific or a guarantee of benefits or payments. If for any reason your insurance, traditional or PPO, denies a claim for services that *they* feel are unnecessary, you will be responsible for the balance. Please refer to your benefits booklet for specific information. You must, however, understand that:

Your deductible if any and "estimated co-payment" are collected at the time of service. We can not guarantee exact amounts to be paid by your insurance carrier. If there is any remaining balance after your insurance has processed your claim, we will forward a balance statement to you. Statements sent are due upon receipt and unpaid balances over 60 days will be subject to finance charges in the amount of 1.5% per month.

We render treatment we feel is in the best interest of the patient, not your insurance company. If you have questions regarding specific procedures, contact your insurance company directly or feel free to ask us to send a pre-authorization to your dental insurance. This process generally takes 4-6 weeks and must be received prior to treatment being rendered.

Missed and broken appointments waste valuable manpower and raise fees for everyone. In an effort to reduce this expensive waste there will be a charge of $35 for each 30 minutes of appointment time. We strictly enforce this policy so please take time to carefully select your appointment times. A broken appointment is classified as the failure to appear for an appointment, cancellations not made 48 hours in advance or lateness that results in an inability to complete scheduled treatment.

If we receive returned checks due to insufficient funds or closed accounts you will be charged $35.

Please understand that if for any reason your account must be placed in the hands of a third party for collections, your account will be charged 1/3 of the total balance for collections fees.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

Signature of Patient or Parent Responsible if Minor Date

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# Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

Obtaining payment from third party payers (e.g. my insurance company);

The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

**Do we have your permission to:**

Send a recall appointment reminder to your home? Yes_____No_____

Leave appointment billing or dental information on your answering machine/voice mail/e-mail: Yes_____No_____

I give permission to share appointment, billing or dental information with the person(s) named: _____

_____

Signed this _____ day of _____, 20____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____