NORTH POTOMAC SMILES

15200 Shady Grove Road, Suite 408
Rockville, MD 20850
301 926 4408

PATIENT REGISTRATION

Patient's Name_____**Birthdate**_____Sex: M F
Address_____Apt#_____Marital status: S M D
City_____State_____Zip Code_____
Soc. Security# _____Home phone_____Work phone_____
If a full time student, what school are you enrolled? _____
Employer's
Name_____Occupation_____Cell#_____
How did you hear about our practice? _____email: _____

Person responsible for account (if different from above)

Relationship to Patient:( )self ( ) spouse ( )parent/guardian *If self, skip to insurance section
Name_____Birthdate_____Sex: M F
Does this person & patient reside in the same household? Yes No
SS#_____
Address_____Apt#_____City_____
State_____ Zip Code_____Home #_____Work#_____

Are you currently covered by Dental Insurance? Yes No
If so please provide us with a copy of your insurance card(s) and driver's license.

Note: Due to the constantly changing insurance rules and regulations, benefits and deductibles, we are only able to approximate your insurance balance/benefits. If your insurance pays more than expected you will be credited the difference. If your insurance company pays less than expected you will be billed the difference. By providing your insurance information you authorize NORTH POTOMAC SMILES LLC to apply benefits on your behalf for services rendered to yourself (or minor/child) and payments to be sent directly to NORTH POTOMAC SMILES LLC.

Office Policies

In order to better serve you in the most consistent, efficient and transparent way possible, we have established the following office policies. Please place your initials by each to indicate that you have read and understood them.

— Payment and/or copayment is required in full at the time services are rendered. If you have dental insurance coverage, please be advised that the co-payment requested for services rendered is ***only an estimate*** based on information that was given to us by your insurance company.

— If you have any questions about your insurance coverage, please let us answer them ***before*** treatment begins. *Otherwise*, the assumption will be that you are familiar with your dental plan coverage and limitations.

— The Doctor and/or hygienist have reserved your appointment time slot ESPECIALLY for you. A minimum of ***24 hour*** notice is required for all appointment changes or cancellation in order to avoid a ***$50*** broken appointment fee.

— There will be a ***$35*** fee for each returned (bad) check that we receive.

— Past due accounts (having a balance for more than 60 days) will be charged a ***1.5% monthly interest rate*** until the account balance is reconciled. Delinquent accounts (unpaid balances of more than 90 days) will be transferred directly to a collections agency.

I, the undersigned, certify that the information I provided is accurate and that have read, understood, and agree to abide by the above polices.

X_____ _____
Responsible Party Signature Date

Medical History

Answering the following questions will provide us with a thorough understanding of your physical condtion for proper recommendations regarding your dental care. This information is strictly confidential.

Do you have or have you ever been treated for:

	YES	NO		YES	NO		YES	NO
Any heart problems			Sickle cell trait			Liver prob/dysfunc		
Heart attack			Blood transfusion			Adrenal / pituitary problem		
Angina			Sexual trans disease			Hepatitis/jaundice		
Bypass			Other infectious disease			Kidney prob/dysfunc		
Pacemaker			Chemotherapy/radiation			Stomach trouble/ulcer		
Stroke			Are you pregnant?			Alcoholism		
High blood pressure			Other growths			Drug abuse		
Low blood pressure			Cancer/Tumor			Nervous/mental disorder		
Heart murmur**			HIV/AIDS			Epilepsy or seizures		
DO YOU NEED TO PRE-MED			Do you smoke?			Thyroid problems		
Mitral valve prolaspe**			Lung/breathing prob.			Allergic to Erythromycin		
Heart valve defect**			Asthma			Allergic to Codeine		
Heart valve replacement**			Bronchitis			Reaction to local Anesthesia		
Rheumatic fever**			Emphysema			Allergic to Penicillin		
Artificial joint**			Tuberculosis			Allergic to Sulfa		
Any bleeding disorder			Sinus trouble			Allergic to Aspirin		
Anemia			Diabetes			Other Allergies		
Hemophilia			Difficulty healing			**List:**		

Do you have any current health problems not noted above? ( )YES ( )NO
If Yes, please explain: _____
Are you currently being treated by a physician? _____ Why? _____
Physician's name and phone_____
Are you presently taking any medications or pills? _____ If yes, please list below.
Drug: _____ purpose: _____
Drug: _____ purpose: _____
Drug: _____ purpose: _____
Emergency Contact : _____ _____ _____
Name Relation to patient Phone

Dental History

Purpose of today's visit: Please check one: ☐ Exam & Clean ☐ Consultation
☐ Pain & Discomfort ☐ Other_____
Are you aware of a problem_____
When was your last dental visit _____When were x-rays last taken _____
Previous dentist's name and address_____
When was the last time your teeth were cleaned_____
Have you ever had an adverse / bad dental experience ?_____
If yes, please explain :_____

Do you think you have any decay	YES	NO	Have you had gum surgery	YES	NO
Do your gums bleed easily	YES	NO	Do you clench or grind your teeth	YES	NO
Do you suffer from bad breath	YES	NO	Interested in permanent replacement of teeth?	YES	NO
Do you have jaw/joint pain	YES	NO	Would you like "whiter" teeth	YES	NO
Are you unhappy w/ appearance of your teeth?	YES	NO	Do you have any concerns	YES	NO
Are your teeth sensitive?	Yes	No	Do you snore?	Yes	No
			If yes, would you consider treatment ?	Yes	No

I certify that the above information is complete and accurate. I authorize examination and treatment as necessary by or under the supervision of the Dentist.

Patient's/Guardian's Signature _____Date_____
Dentist's Signature_____Date_____

NORTH POTOMAC SMILES LLC
15200 Shady Grove Road, Suite 408
Rockvile, MD 20850
(301)926 4408 fax: (301)926-4405

Dear New Patient:

Welcome to our practice. We are looking forward to meeting you and caring for your dental needs. We encourage our patients to maintain good dental health throughout their lifetime. Our goal is to help you eliminate and prevent dental decay and gum disease.

Your first visit will usually include an exam, oral cancer and periodontal screenings, and x-rays as needed. Dr. Nadim Kodsi is responsible for your dental care and requires that a complete exam be done with your cleaning. In order that we complete the exam, we must insist upon current x-rays. **The necessary x-rays will be taken on the first visit unless you have brought with you a current panoramic or full mouth x-ray taken within 3 years and bitewings within the last 6 months**. To minimize exposure to radiation and cost to you, please bring a current full mouth x-ray. For continuity, please obtain a copy of your dental records. If your gum tissue is in good health, we will do a cleaning. If not, the dentist may recommend gum treatment, which may consist of a full mouth debridement. In addition, fluoride treatment may be recommended. If you have any questions about your coverage, please call your insurance or contact our office. Be sure to mention any cosmetic concerns during your initial visit.

We accept most insurance and dental plans and will file claims, when applicable, as a courtesy to you and your family. For dental procedures, which are not covered by insurance at 100%, it will be necessary for you to pay an estimated co-payment and any deductible at the day of treatment. If you are covered by a dental plan (not an insurance plan), payment is required at the time of service to receive the plan's negotiated fee. Our staff can help you with further explanation if necessary.

In order to help us reduce billing expenses and enable us to control costs to our patients, you are responsible for payment on the day of treatment. For your convenience, we accept all major credit cards.

It is essential that you call our office in advance whenever you are unable to keep an appointment because we have reserved the time slot especially for you.

Dr. Nadim Kodsi hopes to provide you with the services necessary to maintain good dental health.

Sincerely,
Office Coordinator

Enclosures:
Welcome letter for first visit, health history, infection control letter, HIPPA forms

Re: Infection Control

The Dentist and staff of our practice are working very hard to protect our patients and ourselves from the spread of infection. As you already know, we learn more and more about the prevention of the transmission of infectious disease such as AIDS, hepatitis and tuberculosis; we have upgraded our infection control practices to insure the safety of our patients and staff.

OSHA has mandated very strict guidelines for the prevention of infection transmission in the dental office. We are working very hard to comply with these regulations. You will note changes in the routine during your treatment visit. You will notice we are using disposable supplies whenever possible; we are wearing facemasks, safety glasses and gloves and we are following the strictest sterilization and disinfection practices. In addition, we are using the heat pressure method of sterilization for instruments and hand pieces. We are proud of our achievements in this area.

We are strongly committed to delivering the best treatment in the safest possible facility. It is your right to be protected against all preventable risks.

We welcome your input and encourage you to feel free to discuss this matter. Please let us know if we can provide further information.

Thank you,
The Dentist and Staff of NORTH POTOMAC SMILES

I have read the above statement:_____ Date:_____

NORTH POTOMAC SMILES LLC
Nadim E Kodsi DDS, AEGD

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. 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 (04/15/03), 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. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

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 physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include 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.
To 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.
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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).**PATIENT RIGHTS Access:** You have the right to look at 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 copies, we will charge you $.50 for each page, $10.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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.)

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 and certain other activities, for the last 6 years, but not before April 14, 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 that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** 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 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 practices or have questions or concerns, please contact us.If you are concerned that we may 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 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 with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Nadim E Kodsi
Telephone: (301) 926-4408 Fax: (301) 926-4405
Address: 15200 Shady Grove Road, Suite 408, Rockville, MD 20850

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

NORTH POTOMAC SMILES LLC
Nadim E Kodsi DDS
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

{Please 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)