Eijah Holness, DDS

WELCOME TO OUR PRACTICE

On behalf of the entire team at Bowie Dental Wellness, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequaled advanced training in cosmetic and reconstructive dentistry we have received.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Personal Information Sheet and Medical and Dental History questionnaire that should be filled out prior to your first appointment with us.

Be sure to visit our website at www.BowieDentalWellness.com. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

Eijah Holness, DDS

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15231 Hall Road, Suite 103 • Bowie, MD 20721 • (301) 390-1300
www.BowieDentalWellness.com

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PATIENT REGISTRATION

Welcome to our office. Please be kind enough to answer the following questions. Thank you so much for being our guest!

Name (Last) (First) (Middle) Date of Birth Sex (M F) Marital Status (S M D W) Social Security Number

How would you like to be addressed? Email Address Cell Phone Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

Name of Employer Occupation Driver's License Number

Business Address (Street) (City) (State) (ZIP Code) Business Phone Number

PERSON RESPONSIBLE FOR ACCOUNT

Who is responsible for account? self spouse parent/guardian other
(Please fill in the following information if the person responsible is different from self.)

Name (Last) (First) (Middle) Social Security Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

Name of Employer Occupation Business Phone Number

INSURANCE INFORMATION

Insured Member (Last) (First) (Middle) Relationship SSN Date of Birth

Name of Employer Occupation Business Phone Number

Business Address (Street) (City) (State) (ZIP Code) Dental Insurance Co.

Group Number ______________________ ID Number ______________________

What are your hobbies? Special interests? ______________________

How did you hear of our office?______________________

If patient was assisted with this form, enter name of person assisting:

Print name Sign name Date

Signature of patient Date

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MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General health (please check): EXCELLENT ❏ GOOD ❏ FAIR ❏ POOR ❏ Name of physician ____________________

Physician's Address ________________________________ Telephone Number __________ Date of Last Physical __________

Are you now under the care of a physician? Yes ❏ No ❏

Are you pregnant or do you think you may be pregnant? Yes ❏ No ❏ If yes, expected delivery date: ____________________

Are you nursing? Yes ❏ No ❏ Are you taking birth control pills? Yes ❏ No ❏

Do you smoke? Yes ❏ No ❏ If yes, how much? ________

Are you taking any medication now? Yes ❏ No ❏ If yes, names of medications and problems for which they are taken:

Medication 1) ______________ Taken for ______________ 3) ______________ Taken For ______________

2) ______________ Taken for ______________ 4) ______________ Taken For ______________

Do you use tobacco? Yes ❏ No ❏

Have you ever required a blood transfusion? Yes ❏ No ❏

Do you or have you used controlled substances? Yes ❏ No ❏

Have you ever taken Fen-Phen or Redux? Yes ❏ No ❏

Are you wearing contact lenses? Yes ❏ No ❏

Do you bruise easily? Yes ❏ No ❏

Have you ever had (please check-mark appropriate boxes):

Abnormal blood pressure .... High ❏ Low ❏ No ❏
AIDS/HIV .... Yes ❏ No ❏
Anemia .... Yes ❏ No ❏
Arthritis .... Yes ❏ No ❏
Asthma or hay fever .... Yes ❏ No ❏
Allergies .... Yes ❏ No ❏
Back problems .... Yes ❏ No ❏
Cancer .... Yes ❏ No ❏
Chemical dependency .... Yes ❏ No ❏
Cold sores/Fever blisters .... Yes ❏ No ❏
Common cold .... Yes ❏ No ❏
Congenital heart lesions .... Yes ❏ No ❏
Diabetes .... Yes ❏ No ❏
Drastic weight loss .... Yes ❏ No ❏
Eating disorders .... Yes ❏ No ❏
Epilepsy/Seizures .... Yes ❏ No ❏
Excessive urination and/or thirst .... Yes ❏ No ❏
Fainting spells .... Yes ❏ No ❏
Glaucoma .... Yes ❏ No ❏
Heart disease .... Yes ❏ No ❏
Heart murmur .... Yes ❏ No ❏
Heart surgery .... Yes ❏ No ❏
Hepatitis .... Yes ❏ No ❏
Jaundice .... Yes ❏ No ❏
Joint replacement or implant .... Yes ❏ No ❏
Kidney trouble .... Yes ❏ No ❏
Mental health care .... Yes ❏ No ❏
Lymph node enlargement (swollen glands) .... Yes ❏ No ❏
Mitral valve prolapse .... Yes ❏ No ❏
Night sweats .... Yes ❏ No ❏
Pacemaker .... Yes ❏ No ❏
Persistent diarrhea .... Yes ❏ No ❏
Prolonged bleeding .... Yes ❏ No ❏
Rheumatic fever .... Yes ❏ No ❏
Sexually transmitted disease .... Yes ❏ No ❏
Sinus trouble .... Yes ❏ No ❏
Swollen ankles .... Yes ❏ No ❏
Stroke .... Yes ❏ No ❏
Thyroid problem .... Yes ❏ No ❏
Tuberculosis or lung disease .... Yes ❏ No ❏
Ulcers .... Yes ❏ No ❏
X-ray treatments for cancer .... Yes ❏ No ❏

If you have entered "yes" to any of the above, please explain: ________________________________

____

Are you allergic to or have you had reactions to:

Local anesthetics like Novocaine .... Yes ❏ No ❏
Penicillin or other antibiotics .... Yes ❏ No ❏
Sulfa drugs .... Yes ❏ No ❏
Barbiturates, sedatives, or sleeping pills .... Yes ❏ No ❏
Codeine .... Yes ❏ No ❏
Aspirin .... Yes ❏ No ❏
Iodine .... Yes ❏ No ❏
Any metal (e.g. gold, nickel, etc.) .... Yes ❏ No ❏
Latex/Rubber .... Yes ❏ No ❏
Tylenol .... Yes ❏ No ❏

Other (please list) ________________________________

Have you had any other serious illness, hospitalization, or accident? ________________________________

____

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms and release Bowie Dental Wellness to utilize any dental photographs for lecturing and educational purposes.

Signature: ________________________________ Date: ________________

YOUR DENTAL NEEDS

Your Name: ______________________ Date: ______________

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Some things we will discuss during your first visit may be issues you have never considered before. Please check what best expresses how you feel about the following questions:

- Are you having any areas of concern? ______________________
- What do you think is the present state of your oral health? ______________________
- What do you already know about our office and what are your expectations? ______________________
- How healthy do you want us to get your mouth? (please circle)

  The best it can be   Average   Don't really care

- Should you need treatment, at what point should we address it? (please circle)

  When something isn't ideal   When something is worsening   When my tooth hurts or breaks

- What quality of dentistry do you want us to recommend? (please circle)

  Ideal/the best   Average   Just patch it

- We have the ability to look at your mouth from three different perspectives. Please rank these in the order of most important to least important to you.

  ___ As a general dentist ___ As a cosmetic dentist ___ As a functional dentist

- How do you feel about the appearance of your face and smile? ______________________
- What would it take for you to trust us to be your dentist? ______________________
- Tell us about your good dental experiences. ______________________
- And the bad ones. ______________________
- Has fear ever been an issue for you in a dental office? ______________________
- What caused you to leave your last dental office? ______________________
- Has time ever been a factor in getting your dental work done? ______________________
- Has cost of dental treatment been a concern for you? ______________________
- What can we do to help you with this? ______________________
- Is there any additional information you would like us to know? ______________________

Eijah Holness, DDS

APPOINTMENT AGREEMENT

At Bowie Dental Wellness, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 24 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 24 hours, you will be subject to a $50 late cancellation charge.

We truly appreciate your understanding. Our goal at Bowie Dental Wellness is to be your partner in health and to assist you in keeping your teeth for a lifetime.

By signing below, I agree to fulfill my obligation as a patient at Bowie Dental Wellness and agree to the "broken appointment" fee should I not give proper notification.

____ ________________________

Signature of patient or responsible party Date

Eijah Holness, DDS

FINANCIAL POLICIES

Here at Bowie Dental Wellness, our office policy regarding financing is as follows: As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment. The practice's vitality depends upon payment for services as rendered and it is the responsibility of the patient/patient's parent/guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior to treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended, at the management's discretion, for payments in full with cash or money order. (Inquire for more details.)

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.) Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan.

A service charge of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation, or at my own request, I agree to pay the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time allotted for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Bowie Dental Wellness and/or Bowie Dental Wellness's financial coordinator to telephone me at home or at my place of business to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

____ Date:______________ Relationship to Patient:__________________

Signature of patient, parent or guardian

____ Date:______________ Relationship to Patient:__________________

Signature of guarantor of payment/responsible party

Eijah Holness, DDS

SOME THINGS YOU SHOULD KNOW ABOUT DENTAL BENEFITS

At Bowie Dental Wellness, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of folks. Some have dental benefits, but most don't. If you have dental benefits, congratulations! You are very fortunate. If you don't, we have numerous ways to make any type of dental care affordable for you. Here are some important things you should know if you do have dental benefits…

Your dental benefits are based upon a contract made between your employer and an employee benefits company. If you have any questions regarding your dental benefits, please contact your employer or the benefits carrier directly.

Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of $1,000. You'll be surprised to know today that the average dental benefit plan has a yearly maximum cap of $1,000. There has been no significant increase in the yearly maximum cap in 50 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It has always been meant to assist you.

Many people receive notification from their insurance company that dental fees are "above usual and customary." A dental benefits company determines their reimbursement level by surveying a geographical area and calculating the average fee, then determines that 80% of the average fee is customary. Included in this survey are discount dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that dental benefit companies define as "*higher than usual and customary.*"

Many dental benefit plans tell their participants that they will be covered "up to 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum, or limitations. It is more realistic to expect dental benefit plans to cover between 25% to 40% of dental services. Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan. You will get back only what your employer has put in, less the insurance company's profit margin.

Dental benefit companies do NOT cover many routine and newer dental services.

Our team members will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We hope you will choose the best that dentistry has to offer.

Eijah Holness, DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ______________________ Social Security # ______________________

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. 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 our office at (301) 390-1300 or by mailing us at 15231 Hall Road, Suite 103, Bowie, MD 20721.

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 address above. Please understand that revocation of this Consent will not affect any action we took 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: ______________________

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

Eijah Holness, DDS

NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *Health care operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.
- The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above. A copy of this authorization (consent) form will be given to me.

Signature:____Date:___________________________

Please contact us for more information:
Bowie Dental Wellness
15231 Hall Road, Suite 103
Bowie, MD 20721
(301) 390-1300
www.BowieDentalWellness.com

For more information about HIPAA or to file a complaint:
The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
202-619-0257 or Toll Free: 1-877-696-6775