



## Gums Dental Care, LLC

8830 Cameron Street, Suite #203  
Silver Spring, MD 20910  
(301) 588-4411

Date: \_\_\_\_\_

### Registration Form

#### Patient Information

##### Name

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Male  Female  Unspecified

Primary Language:  English  Spanish  Other: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

##### Address:

Street: \_\_\_\_\_ City: \_\_\_\_\_

APT \_\_\_\_\_ Zip Code: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_

##### Contact Information:

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Preferred Contact Number:  Home  Cell Email Address: \_\_\_\_\_

##### Emergency Contact:

Name: \_\_\_\_\_ Emergency Phone #: \_\_\_\_\_

##### Do you need antibiotic prophylaxis or pre-medication? Please read below if you are unsure:

Dentists recommend that some patients need to take antibiotics before certain dental procedures. This is called "antibiotic prophylaxis." Antibiotic prophylaxis is recommended for a small number of people who have specific conditions including:

- A history of an infection of the lining of the heart or heart
- A heart transplant in which a problem develops with one of the valves inside the heart.
- Heart conditions that are present from birth
- Orthopedic implants such as artificial joints

Does this apply to you?  Yes  No

##### Your Preferred Pharmacy:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Street: \_\_\_\_\_ Zip Code: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

## Primary Dental Insurance:

Is subscriber the same as patient?  Yes  No

## Subscriber Information:

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Member/ Subscriber ID #: \_\_\_\_\_ Group/Contract Number: \_\_\_\_\_

Member/ Subscriber Date of Birth: \_\_\_\_\_

Patient Relationship to Subscriber:  Child  Disabled Dependent  Spouse  Self

Subscriber SSN: \_\_\_\_\_

## Consent Form

### Patient Name

First: \_\_\_\_\_ Initial: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize **ANNA A. GUMBS, DMD** and to whomever the dentist designates as an assistant, to carry out the following operations and / or procedures upon me: **Dental treatment**

I request and authorize the dentist to do what he considers necessary in the event that unforeseen events arise during the course of these operations and / or designated procedures and that, in accordance with the judgment of the dentist, require the performance of additional or different procedures than those they are detailed above.

I give my consent to the treatment mentioned above after being notified about the risks, advantages and disadvantages of the treatment and the consequences of not taking place.

I give my consent to the treatment plan mentioned above, after having been notified about the available alternative treatment plans and the material risks, known advantages and disadvantages of the alternative treatment.

I also give my consent for the administration of general or local anesthesia, antibiotics, analgesics, and any other medication deemed necessary in my case, and I understand that there is a slight element of risk inherent in the administration of any medication or anesthesia. This risk includes adverse drug reactions (e.g. allergic reactions), cardiac arrest, aspiration, thrombus phlebitis (irritation and swelling of the veins), pain, discoloration, and injury to blood vessels and nerves induced by injection, medicine, or drugs.

I am fully informed and understand that all types of surgery have inherent inevitable complications. In the case of oral surgery, the most common complications are postoperative bleeding, swelling or bruising, discomfort, mandibular stiffness and loss or loosening of dental shavings. Less common complications include infection, loss or damage to teeth and soft tissues and adjacent, nerve disorders (numbness of oral and root tissues remaining in the jaw, whose removal may require more.

I am aware that, despite the complications and possible risks, the surgical intervention or the treatments considered are necessary and desired by me. I know that dental and surgical practice is not an exact science and I understand that I have not been given guarantees regarding the results of the operation or procedure.

I have provided medical and personal history as accurate and complete as possible, including antibiotics, drugs, medicines and foods to which I am allergic. I will follow any instructions, as they are explained and indicated, and I will allow the carrying out of the recommended diagnostic procedures.

Before signing this form I have had the opportunity to ask questions and receive answers and adequate explanations for all questions about my medical condition treatments and procedures considered alternative, risks and possible complications of the contemplated and alternative treatments and procedures.

Patient's or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History Form

**Patient name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

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 you will receive. Thank you for answering the following questions.

- |   |  |                               |
|---|--|-------------------------------|
| Are you under a physician's care now?   | <input type="radio"/> Yes <input type="radio"/> No | If yes, please explain: _____ |
| Have you ever been hospitalized or had a major operation?   | <input type="radio"/> Yes <input type="radio"/> No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury?  | <input type="radio"/> Yes <input type="radio"/> No | If yes, please explain: _____ |
| Are you taking any medications, pills, or drugs?  | <input type="radio"/> Yes <input type="radio"/> No | If yes, please list: _____    |
|   |  |                               |
| Do you take, or have you taken, Phен-Fen or Redux?  | <input type="radio"/> Yes <input type="radio"/> No |                               |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | <input type="radio"/> Yes <input type="radio"/> No |                               |
| Are you on a special diet?  | <input type="radio"/> Yes <input type="radio"/> No |                               |
| Do you use tobacco?   | <input type="radio"/> Yes <input type="radio"/> No |                               |
| Do you use controlled substances?   | <input type="radio"/> Yes <input type="radio"/> No |                               |

**Women: Are you** \_\_\_\_\_

Pregnant/Trying to get pregnant?  Yes  No      Taking oral contraceptives?  Yes  No      Nursing?  Yes  No

**Are you allergic to any of the following?**

Aspirin    Penicillin    Codeine    Local Anesthetics    Acrylic    Metal    Latex    Sulfa Drugs    Other

If other, please explain: \_\_\_\_\_

**Do you have or have you had any of the following?**

- |   |  |   |
|---|--|---|
| <p>AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No</p> <p>Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Anemia <input type="radio"/> Yes <input type="radio"/> No</p> <p>Angina <input type="radio"/> Yes <input type="radio"/> No</p> <p>Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No</p> <p>Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No</p> <p>Artificial Joint <input type="radio"/> Yes <input type="radio"/> No</p> <p>Asthma <input type="radio"/> Yes <input type="radio"/> No</p> <p>Blood Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No</p> <p>Breathing Problem <input type="radio"/> Yes <input type="radio"/> No</p> <p>Bruise Easily <input type="radio"/> Yes <input type="radio"/> No</p> <p>Cancer <input type="radio"/> Yes <input type="radio"/> No</p> <p>Chemotherapy <input type="radio"/> Yes <input type="radio"/> No</p> <p>Chest Pains <input type="radio"/> Yes <input type="radio"/> No</p> <p>Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No</p> <p>Congenital Heart <input type="radio"/> Yes <input type="radio"/> No</p> <p>Disorder Convulsions <input type="radio"/> Yes <input type="radio"/> No</p> <p>Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No</p> <p>Diabetes <input type="radio"/> Yes <input type="radio"/> No</p> <p>Drug Addiction <input type="radio"/> Yes <input type="radio"/> No</p> <p>Easily Winded <input type="radio"/> Yes <input type="radio"/> No</p> <p>Emphysema <input type="radio"/> Yes <input type="radio"/> No</p> <p>Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No</p> | <p>Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No</p> <p>Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No</p> <p>Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No</p> <p>Frequent Cough <input type="radio"/> Yes <input type="radio"/> No</p> <p>Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No</p> <p>Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No</p> <p>Genital Herpes <input type="radio"/> Yes <input type="radio"/> No</p> <p>Glaucoma <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hay Fever <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heart Murmur <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hemophilia <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hepatitis A <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No</p> <p>Herpes <input type="radio"/> Yes <input type="radio"/> No</p> <p>High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No</p> <p>High Cholesterol <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hives or Rash <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No</p> <p>Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No</p> <p>Kidney Problems <input type="radio"/> Yes <input type="radio"/> No</p> <p>Leukemia <input type="radio"/> Yes <input type="radio"/> No</p> <p>Liver Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No</p> | <p>Lung Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No</p> <p>Osteoporosis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No</p> <p>Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No</p> <p>Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No</p> <p>Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No</p> <p>Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No</p> <p>Rheumatism <input type="radio"/> Yes <input type="radio"/> No</p> <p>Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No</p> <p>Shingles <input type="radio"/> Yes <input type="radio"/> No</p> <p>Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No</p> <p>Spina Bifida <input type="radio"/> Yes <input type="radio"/> No</p> <p>Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No</p> <p>Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Tonsillitis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Tuberculosis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No</p> <p>Ulcers <input type="radio"/> Yes <input type="radio"/> No</p> <p>Venereal Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No</p> |
|---|--|---|

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

**Signature of PATIENT, PARENT, or GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

Gums Dental Care, LLC  
8830 Cameron Street, Suite 203  
Silver Spring, MD 20910  
Phone: (301) 588-4411

**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.**

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

### TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for care for other health care or services; or getting copies of your health information from other professionals that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons we usually will not ask you for special written permission.

### USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
  - for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
  - Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence
  - Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
    - Disclosure for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies
    - disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else
    - disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
  - Uses or disclosures for health related research
  - Uses and disclosures to prevent a serious threat to health or safety
  - Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the Foreign Service;
  - Disclosure of de-identified information
  - Disclosures relating to worker's compensation programs
  - Disclosures of a "limited data set" for research, public health, or health care operations
  - Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
  - Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information
- Unless you object, we will also share relevant information about your care with your family or friends who are helping with your dental care.

### APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on our home answering machine or with someone who answers your phone if you are not home.

### OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". Federal law determines the content of an "authorization form". Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this notice.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the public information officer at the address, fax or e-mail shown at the beginning of this notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site) You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this notice
- Ask us to amend your health information if you think that is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your protected health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax, or email shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension, in writing. If you want a list, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this notice.
- Get additional paper copies of this notice of privacy practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the public information officer at the address, fax or e-mail shown at the beginning of this notice.

**OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by terms of this notice of privacy practices until we choose to change it. We reserve the right to change this notice at any times as allowed by law. If we change this notice, then new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our notice of privacy practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

**COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact at the address, fax or e-mail shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

**FOR MORE INFORMATION**

If you would like more information about our privacy practices, contact the HIPAA officer at the address, phone number, or email address shown at the beginning of this notice.

-----Tear here -----

**ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I received a copy of Anna A. Gumbs’ Notice of Privacy Practices.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_