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: _____

Name of Spouse, Parent, or Guardian: _____

Patient's 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: _____

Reason for Visit: What is the main problem that the patient is concerned about?

_____

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

Name of Patient, Parent, or Guardian

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 alterative 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's 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?	○ Yes ○ No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes, please list: _____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	
Have you ever taken Fosamax, Boniva, Actonel or any other	○ Yes ○ No	
medications containing bisphosphonates?	○ Yes ○ No	
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ 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?

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

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** _____

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.

ACKNOWLEDGEMENT OF RECEIPT

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

Name of Patient, Parent, or Guardian: _____

Signature: _____ Date: _____