Malcomson
DENTISTRY

Patient Registration

Name: _____ Date of Birth: _____/_____/_____
Last First M.I.

Address: _____

City: _____ State: _____ Zip Code: _____

Home: (____)_____ Cell: (____)_____ Work: (____)_____

Email: _____@_____.com Preferred method (circle): Email / Text / Phone Call

Occupation: _____ Company: _____

Address: _____

In case of Emergency, whom should we contact:

Name / Relationship: _____ Phone Number: (____)_____

Preferred Pharmacy / Location: _____ Phone Number: (____)_____

Malcomson Dentistry accepts the following forms of payment: MasterCard, VISA, DISCOVER, Cash and Check

Who is financially responsible for this account? _____ Relationship: _____

I understand and agree that (regardless of insurance status) I am ultimately responsible for the fees changed on my account, for professional services rendered at Malcomson Dentistry. I reviewed, completed and signed all of the required forms: Patient Registration, Health History, Health Insurance Portability & Accountability Act (HIPAA) and the Acknowledgment of Receipt of Notice of HIPAA Privacy Practices prior to my dental appointment. I hereby certify the above information on any forms to be true and correct to the best of my knowledge and will notify Malcomson Dentistry should any changes occur in my health status or if the above information changes. I understand charges may be applied for missed appointments without at least 24 hours notice.

Patient or Guardian's Signature: _____ **Date:** _____/_____/_____

8218 Wisconsin Avenue, Suite 415, Bethesda, Maryland 20814 O: (301) 656-1588 E: MalcomsonDentistry@gmail.com

Malcomson Dentistry

Patient Medical History

Patient Name: _____ **Approx. date of last physical:** ___/___

Primary care physician: _____ Phone number: (___) _____

Preferred Pharmacy/ Location: _____ Phone Number: (___) _____

List All medications: (prescription/non-prescription, homeopathic/herbal supplements, essential oils and recreational)

_____

_____

Are you currently under medical care? If yes, please specify: _____

In the past 5 years, have you had surgery (joint, cosmetic etc.) a serious medical illness or significant weight loss? If yes, please specify: _____

Have you ever taken (circle): Fen-Phen, Dexfenfluramine/Bisphosphonates?		Y	N
Do you currently (circle): Chew tobacco/smoke/vape/e-cigarette?		Y	N
Are you pregnant or think you may be pregnant/breast feeding?	Y	N	N/A
Are you using and form of contraception: Oral or implanted?	Y	N	N/A

Circle ALL medical conditions:

Asthma/ Hay Fever
Sinus Problems
Asthma
Respiratory Disease/ COPD
Pneumocystis
Emphysema
Tuberculosis
Acid reflux/Ulcer
Arthritis/ Rheumatism
Back Problems
Osteoporosis
Blood Transfusion
Cancer Treatment:
Chemo/Radiation Therapy
HIGH Blood Pressure
LOW Blood Pressure
Fainting Spells
Rheumatic fever
Anemia
Abnormal bleeding
Hemophilia
Sickle Cell Disease

COVID
Joint Replacement
Other Implant(s):_____
Angina Pectoris
Congenital Heart Defect
Heart Murmur/ Attack
Cardiac incident/Pacemaker or Atrial Fibrillation
Artificial Heart Value
Heart Value Replacement
Mitral Value Prolapse
Stroke
Circulatory Problems
Edema/ Swelling of Ankles/Feet
Colitis/ IBS
Epilepsy
Seizures
Contact Lenses/ Cataracts
Glaucoma
Headaches/ Migraines
Diabetes

Kidney/ Bladder Disease
Liver Disease/Jaundice
Shingles
Cortisone/Steroid Therapy
Thyroid/Parathyroid
Psychiatric Care
Alcohol Dependency
Drug/Substance Abuse
Chemical Dependency
Hepatitis: _____
STI(s) _____
Immune Def. Disorder:
AIDS / HIV / ARC

List/circle **All** allergies:
Antibiotics-Aspirin-Codeine
Dental Anesthetic-Latex
Erythromycin-Jewelry-Metals
Local anesthetic(s)-Penicillin
Sulfa drugs- Tetracycline
_____
_____
_____

Vaccinations: Anthrax, Adenovirus, Chickenpox, Flu (Influenza), COVID, Hepatitis A or B, HPV, MMR, Meningococcal (MenACWY, Men B,) Pneumococcal, Polio, Rabies, Rotavirus, Shingles, Smallpox, Tdap, Tuberculosis, Yellow Fever or other vaccine not listed or adverse reaction _____

I attest to the best of my knowledge, that I have honestly answered all medical Questions and listed all allergies. I understand that providing incorrect or misinformation can be dangerous to my health and Dr. Ellen D Malcomson and Malcomson dentistry staff will not be responsible for errors and omissions that I make on this form.

Patient or Guardians Signature: _____ **Date:** ___/___/___

Ellan D. Malcomson, D.D.S.

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 request to the Privacy Officer: 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

• 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.

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.

Contact office:
Ellen D. Malcomson, DDS
8218 Wisconsin Ave., Suite 415
Bethesda MD 20814
301-6756-1588
301-656-1588
www.MalcomsonDentistry.com

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

Malcomson
DENTISTRY

ACKNOWLEDGMENT OF RECEIPT
- NOTICE OF PRIVACY PRACTICES –

I, _____ have read a copy of this

office's 'HIPAA Notice of Privacy Practices'. I fully understand that I may request a copy of Malcomson Dentistry's 'HIPAA Notice of Privacy Practices' and a copy of my 'Acknowledgment of Receipt of Notice of Privacy Practices.' A Patient may refuse to sign this document.

_____ ____ / ____ / ____

Signature ***(Parent/ Legal Guardian MUST sign if patient is under the age of 18)*** **Date**

---------- ***For Office Use ONLY*** ----------

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice, but acknowledgment could not be obtained because:

- ○ *Individual refused to sign.*
- ○ *Communication barriers prohibited this office from obtaining acknowledgment.*
- ○ *An emergency situation prevented this office from obtaining acknowledgment.*
- ○ *Other (please specify):* _____.

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