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Thank you for trusting us with your dental care.
We promise to do our best to provide you with
the finest care available. If you have any
questions please do not hesitate to call us.

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____
Address _____ City _____ State _____ Zip _____
Sex M F Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Home Phone # () _____ Cell Phone #1 () _____ Cell Phone #2 () _____
Employer _____ Employer Phone () _____
Employer Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone () _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone () _____

RESPONSIBLE PARTY

Name of Person _____
Responsible for this Account _____ Relation to Patient _____
Address _____ Home Phone () _____
Birthdate _____ Currently a patient in our office? Yes No
Employer _____ Work Phone () _____
E-Mail _____ Cell Phone () _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone # () _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone # () _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have or have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collecting between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, FastIn (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you ever had any serious illnesses or operations?? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had problems with any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart lesions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic fever | |

List medications you are currently taking:

Allergies:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Latex	
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	<input type="checkbox"/> None	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

 Signature of Patient, Parent, Guardian or Personal Representative

 Date

 Please print name of Patient, Parent, Guardian or Personal Representative

 Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below
and read and sign the section at the bottom of form.

Patient Name _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings _____ Bridges _____ Crowns _____ Extractions _____
Impacted teeth removed _____ General Anesthesia _____ Root Canals _____ Other _____
(Initials _____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
(Initials _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.
(Initials _____)

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
(Initials _____)

5. CROWN, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.
(Initials _____)

6. DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
(Initials _____)

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
(Initials _____)

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.
(Initials _____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date _____

Signature of Parent/Guardian if patient is a minor _____ Date _____

**Consent For Use And Disclosure Of Health
Information**

Section A Patient Giving Consent

Name: _____

Telephone: _____ Email: _____

Section B To Patient --Please Read The Following Carefully

Purpose Of Consent: By signing this form , you are consenting to our use and disclosure of your Protected Health Information (PHI) to carry out Treatment, Payment activities and healthcare Operation (TPO):

With this consent, our office staff may call your home or other alternative and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out (TPO), such as, but not limited to, appointment reminders, insurance, insurance/account items and information pertaining to your clinical care, including favorable laboratory results.

With this consent, our office staff may mail, or send via electronic mail(e-mail), to your home or other alternative location any items that assist the practice in carrying out (TPO), such as appointment reminders cards and account or patient statements.

With this consent, you understand that our office WILL maintain a sign in sheet for all patients to sign upon arrival , however this sign in sheet will not list a reason for the visit. Additionally, schedules that include a patient's name may be posted throughout the office to assist the staff in healthcare operations, however the reason for the patient's visit will not be listed in a text that is readable to other patients.

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 the uses and disclosures we may make of the treatment, payment activities, healthcare operations, and of other important matters concerning your protected health information. A copy of your notice accompanies this consent. 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 revision to our notice at any time by contacting the office manager.

You have the right to request that our office staff restrict how it uses or discloses you (PHI) to carry out (TPO). However , the practice is not required to agree to your requested restriction, if it does , it is bound by this consent.

Signature: _____ Date: _____

White Marsh Dental Group



Financial Policy

Dear (patient): _____

Thank you for selecting us as your dental health care provider. The following information describes our financial policy. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask us.

We ask that you read and sign our financial policy. Also, we ask that you complete our patient information form prior to seeing the dentist.

Payment for service is due at the time services are rendered. We accept personal checks, and for your convenience, Master Card, Visa, or Discover credit cards. We will help you process your insurance claim for your reimbursement if we have complete insurance information and if you bring a complete claim form with you to your appointment. In special instances, we accept assignment of insurance benefits.

HOWEVER, Please be aware:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our financial relationship is with YOU, and NOT your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Our financial relationship is with YOU, NOT your insurance company.
3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatments.
4. If the insurance company does not pay your balance in full within thirty (30) days, we will ask that you contact the carrier to help speed things up.
5. If the insurance company does not pay your balance due, in full, within forty-five (45) days, we will require you pay the remaining balance due with CASH, PERSONAL CHECK, MASTERCARD, VISA, or DISCOVER. Outstanding balances older than ninety (90) days may be subject to an eighteen percent (18%) APR interest charge and additional collection and or legal fees. Returned checks will have an additional fee of thirty dollars (\$30.00) added to the check amount. A duplication fee of twenty-five dollars (\$25.00) may be charged to co-pay an x-ray. You may request a copy of your record for an additional fee.
6. Please note that unless you cancel your appointment at least twenty-four (24) hours in advance, you may be charged for a missed appointment at the rate of our normal office visit. Please call the office as soon as possible if you have to reschedule.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account.

Again, thank you for choosing White Marsh Dental Group as your dental health care provider. We appreciate your confidence in us and the opportunity to serve you.

Patient/Parent or Guardian Signature: _____ Date: _____

