



Chart # \_\_\_\_\_

# Robert J. Kelly, DDS

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## & Associates, PA

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### Mission Statement:

“My associates and I are sincerely committed to providing you with the most advanced dental techniques and pain-free treatments in a friendly and comfortable environment.”

Referred by: \_\_\_\_\_

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Name as on Insurance: \_\_\_\_\_

Sex: Male Female Marital Status: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ (\*Required for insurance claims)

Address: \_\_\_\_\_

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

Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Work#: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**Accounting Information** - If same as above please check here  ; If not, please fill out the following

Relationship to Patient: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Drivers License #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address: \_\_\_\_\_

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

Home #: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell#: ( \_\_\_\_\_ ) \_\_\_\_\_

Employer: \_\_\_\_\_ Work#: ( \_\_\_\_\_ ) \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Insurance Information

Insurance Company Name: \_\_\_\_\_ Insurance Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Insurance Address: \_\_\_\_\_

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

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employer of Policy Holder: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

### Emergency Contact Information

Whom may we contact in case of a medical emergency?

Name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Relation to Self: \_\_\_\_\_

### Dental History

Reason for today's visit: \_\_\_\_\_

When did you last see a dentist? Month \_\_\_\_\_ Year: \_\_\_\_\_

Treatment Received: \_\_\_\_\_

Were X-rays Taken? \_\_\_\_\_ Type of X-rays? \_\_\_\_\_

How often do you normally visit a dentist? \_\_\_\_\_

Have you had any problems associated with past dental treatment?  Yes  No **If yes, please explain:**

\_\_\_\_\_

How would you rate your present oral health?  Good  Fair  Poor

## Medical History

In order to provide you with the best possible dental care, it is necessary that we know as much about your medical history as possible prior to treatment.

**Circle the appropriate answers below:**

Are you currently under the care of a physician?	Y	N
Name of Physician:	Phone #: (      )	-
Have you had any recent illness or surgery?	Y	N
If yes, please explain:		
Have you been hospitalized in the last 5 years?	Y	N
If yes, for what?		
Are you taking any drugs, medicines or herbal supplements?	Y	N
If yes, please list:		
Are you allergic to any food or drug?	Y	N
If yes, please specify:		

### **Have you had...**

Any unusual reaction to local anesthetic	Y	N
Sleep Apnea problems	Y	N
Heart Problems	Y	N
Stroke or arterial spasms	Y	N
High Blood Pressure	Y	N
Nervous System disorders (i.e. Seizures, Cerebral Palsy, Epilepsy)	Y	N
Blood Disorders (i.e. Anemia, Leukemia, Delay in clotting time)	Y	N
Diabetes	Y	N
Hepatitis or liver disease	Y	N
Venereal disease (i.e. herpes, syphilis, gonorrhea)	Y	N
Aids or HIV	Y	N
Tuberculosis or Positive TB test	Y	N
Kidney or Urinary Problems	Y	N
Arthritis or Rheumatism	Y	N
Cancer or Tumor	Y	N
Stomach or Digestive Disorders	Y	N
Lyme Disease	Y	N
Pain, pressure, tightness, in the chest upon exertion	Y	N
Shortness of breath or breathing problems	Y	N
Swelling of ankles	Y	N
Persistent Cough	Y	N
Bruise easily	Y	N
Prolonged bleeding or delayed healing	Y	N
Frequent Headaches	Y	N
Dizziness or Fainting	Y	N
Frequent Urination	Y	N
Weight gain or loss of more than 10 lbs	Y	N
Radiation therapy for any oral or physical condition	Y	N
Osteoporosis	Y	N
Osteopenia	Y	N

**For Women:**

Are you pregnant?	Y	N
Are you taking birth control pills?	Y	N
Are you in or have you been through menopause?	Y	N
Are you under estrogen replacement therapy?	Y	N

**Is there any additional information about your health that has not been covered above?**

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**Payment Agreement**

The Undersigned agrees to pay for any interest on overdue accounts, collection fees, and/or reasonable legal fees (if legal action is required for the collection of this account) necessary in the management of any credit extensions with Robert J. Kelly, D.D.S. and Associates, P.A.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Important Office Policy****I. Appointment Scheduling Policy**

All dental appointments, once scheduled, are considered reserved and confirmed. We will give you a courtesy reminder call or leave a message on your answering machine 2-3 days prior to your dental appointment. This call serves as a **courtesy** reminder of your appointment.

However, it is ultimately your responsibility to be here as scheduled. If you cannot make your appointment, we expect no less than 24 hours notice. Please note: a charge of \$50.00 per patient will be applied to your account, for appointments broken without a full 24 hours notice.

The policy is necessary due to the increasing number of patients canceling or failing their appointments. We can no longer give our patients this luxury.

**II. Methods of Payment**

Your chosen payment method must be established with the receptionist before the start of any treatment. All charges from the date of service are your responsibility. Please review the below options for methods of payment. A copy of your insurance identification card and drivers license is needed for all credit arrangements.

**Dental Insurance:** Please provide all insurance information as requested on this form. Refer to *Section III—“Dental Insurance Policies”* for further detailed information.

**Cash**

**Check:** We will be happy to accept your check provided that you are able to show us your current Drivers License or other equivalent State issued ID.

**Credit Cards:** Visa, Mastercard, Discover and American express are accepted.

**CareCredit Financial Plan:** Financing options are available through CareCredit. If approved, they offer up to a 12-month interest-free payment plan. Please contact our financial coordinators for more details.

**In House Payment Plan:** A minimum of 50% of the treatment costs is required to institute this plan and the remainder is payable in equal monthly installments, the total must be paid within 90 days.

-Please note that returned checks and balances older than 60 days will be subject to additional collections fees and interest charges of 1% per month.

-Also, please note that any uncollected balance that is turned over to court will be subject to reasonable lawyer fees and interest.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account at (240) 243-0500.

### **III. Dental Insurance Policies**

We must emphasize that as dental care providers our relationship is with you, not that of your insurance company. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

Our fees are generally considered to fall within the acceptable range by most insurance companies and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. fees. "UCR" is defined as usual, customary and reasonable by most insurance companies.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. All charges from services rendered are your responsibility.

Your co-pay and deductible are expected at the time of service. The co-pay is based on the estimated patient responsibility percentage of the UCR fee (as provided to us by your insurance company). Once payment by insurance is received, charges may differ according to insurance contract and coverage.

We submit to all primary dental insurance claims as a courtesy extended to our patients. We will gladly provide a reasonable amount of information requested by insurance for the claims and pre-treatment estimates at no charge. Your insurance company has 30 days by Maryland law to approve or deny each received claim. Your monthly statement will show whether or not insurance has paid a claim. We add finance charges to your account after 60 days, whether your insurance has paid or not.

For those with more than a single insurance coverage, it is our policy to file only the claims for the insurance that is considered to be the primary carrier.

The receptionist will provide you with a walk out statement at the end of each appointment. The statement will list all services rendered that day. You may use this to check on the status of your claim, as we cannot afford to follow up on each claim we submit. The average "hold" time we experience when calling insurance to check claim status, is 2 to 20 minutes.

As a Preferred Provider Organization (PPO) participant, our office must accept 20% to 30% less than our usual and customary fees in order to participate in these insurance plans. Please note that although we will continue to file claims at no charge to you, there will be a **minimum of \$25.00 fee for every claim we are asked to research and/or re-file.**

#### IV. Agreement and Authorization

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I hereby Authorize (A) Robert J. Kelly DDS and Associates, P.A. to release information necessary to my insurance carrier(s) concerning the dental treatment for me or my dependents (B) authorize payment of all dental insurance benefits for services rendered to be paid to Robert J. Kelly DDS and Associates, P.A. (C) A Photostat of this authorization shall be valid as an original.

I understand that I am responsible for any balance determined by my insurance carrier to be the patient's responsibility and for any services that are not a covered expense by that company.

My below signature affirms that I have read and agree to the above terms.

Name of Patient/ Guardian (Please Print): \_\_\_\_\_

Signature of Patient/ Guardian: \_\_\_\_\_ Date: \_\_\_\_/ \_\_\_\_/ \_\_\_\_

ROBERT J. KELLY, DDS & ASSOCIATES , PA

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## NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning health information. This Notice takes effect 1/13/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to use of your health information for treatment, payment of healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health care information to notify, or to assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health Related Services:** We will not use your health information for making communications without your written authorization.

**Required By Law:** We may use or disclose your health information when required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.60 for each page, or \$ 22 per hour for staff time to locate and copy your health information, and postage if your want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer we will prepare a summary or an explanation of your health information for a fee. Contact us by using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation for how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this notification in written form.

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### **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or concerns please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Robert J. Kelly  
Telephone: (240) 243-0500 Fax: (240) 243-0504  
Address: 220 Main Street (Business Office)  
Gaithersburg, MD 20878