Aslim Abdullah, D.D.S.,F.A.C.D.
And Associates
14333 Laurel-Bowie Rd., Suite 300 Laurel, MD 20708
(301) 776-1030

PATIENT INFORMATION: (PLEASE START ON 1ST LINE BELOW)

PATIENT'S NAME DATE

ADDRESS CITY STATE ZIP

MARITAL STATUS SEX: M/F PATIENT'S AGE DATE OF BIRTH

HOME PHONE CELL PHONE WORK PHONE

E-MAIL ADDRESS WOULD YOU LIKE OUR OFFICE TO CONTACT YOU VIA E-MAIL? Y/N
(THIS MAY BE IN REGUARDS TO APPOINTMENTS AND BILLING INQUIRIES)

PATIENT'S EMPLOYER

REFERRING DENTIST

IN CASE OF EMERGENCY, NOTIFY RELATIONSHIP PHONE #

HAVE YOU BEEN TREATED IN OUR OFFICE BEFORE: Y/N IF SO, WHEN?

RESPONSIBLE PERSON IF OTHER THAN PATIENT:

NAME DATE OF BIRTH

ADDRESS PHONE

PRIMARY DENTAL INSURANCE:

NAME OF INSURANCE COMPANY

POLICY HOLDER NAME POLICY HOLDER DOB

POLICY HOLDER ID# POLICY HOLDER SSN#

IS THIS VISIT DUE TO AN ACCIDENT? IF SO, PLEASE GIVE DATE AND DETAIL

SECONDARY INSURANCE INFORMATION

I hereby authorize release of any information to the insurance company relating to my dental claim. I also authorize payment directly to Dr. Aslim Abdullah of the insurance benefits otherwise payable to me.

Signature of Patient_____

OVER

MEDICAL HISTORY

1. Is your general health good? _____
2. Are you under a physician's care now? If yes, for what
   _____
3. Do you take a daily Aspirin or blood thinner? If yes, list medicine:_____
4. Do you have any allergies to medications, anesthesia or **LATEX**? If yes, please list
   _____
5. Do you take any kind of medication (prescribed or non-prescribed) or drug at this time? If yes, please explain_____
6. Do you require **pre-medication** of antibiotics prior to dental treatment? If yes, for what _____(this is not due to an infection in your tooth)

Please circle any of the following below which you have and/or had:

- Tuberculosis
- Hepatitis
- Heart Trouble
- Epilepsy
- HIV/(AIDS)
- Radiation Therapy
- Asthma
- Liver Trouble
- Nervous Disorder
- Heart Murmur
- Kidney Trouble
- Fainting Spells
- Diabetes
- Blood Disorders
- High Blood Pressure
- Pregnant if so what trimester?_____
- Artificial Joints/ Screws/ Rods, Explain:_____

Is there anything else about your health we should know? _____

I verify the above medical history and information to be true to the best of my knowledge.

Patient/Parent/Guardian Signature_____ Date_____

Doctor's Initials _____ Date_____

ASLIM ABDULLAH, D.D.S., F.A.C.D. AND ASSOCIATES
LAUREL ENDODONTICS
(301)776-1030
OUR CREDIT POLICY

We feel that everyone benefits when there is a definite financial agreement prior to treatment. An estimate of your total fee will be given on consultation. To make your financial agreement as clear as possible, we have the following methods of payment:

*Payments can be distributed in accordance with the number of appointments needed to complete the treatment assisted by treating doctor.

Plan 1- If you have NO INSURANCE- 50% of the fee for service is required at the time treatment is started. However, if treatment is completed in one appointment the total co-pay is due at time of service.

Plan 2 – If you have INSURANCE that requires you to pay a certain percentage of treatment that said percentage will be due at the time of treatment.
Please remember that policies are contracts between the patient and the insurance company, but for your convenience, we will submit insurance forms for you.

PLEASE NOTE:
There will be a $35.00 service charge for all returned checks.

There will also be a $50.00 minimum service charge for appointments broken without 24-hour notice.

Any accounts that are sent to our collection attorney will be given a $30.00 service charge.
*For your convenience, we accept checks, Mastercard, Visa, Amex, Discover & Cash

***Any fees unpaid by the insurance company will be at the patient's responsibility._____(Patient/ Parent or Guardian initials)**

I hereby certify that I have fully read and agree with all terms and conditions.
The below signature also verifies patient copy receipt of the Notice of Privacy Practices.

Estimated fees for services rendered depending per tooth upon insurance payment

Consult: **Tooth#:** **Tooth#:** **Deductible:**

Signature_____ Date_____

OVER

Dr. Aslim Abdullah
Notice of Privacy Protection

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 PROTECTED HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect September 23, 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and 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 protected health information that we maintain, including protected 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 applicable upon request.

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

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

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

Treatment: We may use and disclose your protected health information to a dentist, hygienist or other healthcare providers for treatment purposes.

Payment: We may use and disclose your protected health information to bill for and collect payment for services we provide to you.

Healthcare Operations: We may use and disclose your protected health information in connection with our healthcare operations. Health care operations include quality assessment and improve activities, reviewing the competence or qualifications of healthcare providers, evaluating provider performance, conducting training programs, peer review, accreditation, certification, licensing, or credentialing activities.

Authorization: In addition to our use and disclosure of your protected health information for treatment, payment or healthcare operations, you may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You may revoke such authorizations at any time by written request, but we cannot take back any uses or disclosures already made with your permission. Unless you give us a written authorization, we cannot use or disclose your protected health information for any reason expect those described in this Notice.

To Your Family and Friends: We may disclose protected health information about you to your family members or friends if we obtain your verbal authorization to do so if we give you an opportunity to object and you do not object. We also may disclose protected health information to your family or friends if we can infer from the circumstances, based on your reasonable judgment, that you would not object, for example when you bring your spouse with you when treatment is discussed. We may use our professional judgment to infer that it is in your best interest to allow another person to pick-up filled prescriptions, medical supplies, x-rays or recommend that they take you to your physician or emergency room.

We may use or disclose protected health information to notify or 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, or your general condition. If you are present, then prior to use or disclosure of your protected health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose protected health information based on a determination using our professional judgment, disclosing only protected health information that is directly relevant to the persona's involvement in your healthcare.

Marketing Health-Related Services: We may use or disclose protected health information for marketing purposes with you written authorization.

Required By Law: We may use or disclose protected health information when we are required to do so by federal, state, or local law or legal process, for example, subpoena, court order, administrative order, warrant, or summons; and pursuant to workers' compensation laws.
Abuse or Neglect: We May disclose your protected 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 protected health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
Government Officials and Law Enforcement: We may disclose to authorized governmental officials protected health information required for lawful investigation, military authorities, the protected health information of Armed Forces personnel, and a correctional institution or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose protected health information to provide you with appointment reminders (such as postcards, voicemail message, or letters) or information about oral health care, and related benefits and services.

PATIENT RIGHTS
Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, postage and staff time. If you request an alternative format that we can practicably provide, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary, or an explanation, of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fees.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before September 23, 2007. 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 in writing that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to agree to requests that we not disclose protected health information to your health plan with respect to services for which you have paid out of pocket in full.
Alternative Communication: You have the right to request that we communicate with you about your protected 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 how payments will be handled under certain circumstances.
Amendment: You have the right to request that we amend your protected 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.
Breach Notification: You have the right to receive notice if the security of your unsecured protected health information is breached.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive a paper copy of this Notice upon request.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you by alternative means or at alternative locations, you may submit a complaint to us using the contact information listed at the end of this Notice. You also may 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 protected health information. You will not be penalized in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Patient Rights Information:	60 Market St, Ste 209 Gaithersburg, MD 20878Gaithersburg, MD 20878	Complaints:	60 Market St, Ste 209