Anthony Narlis, D.D.S., F.I.C.O.I.
Johanna Narlis, D.D.S.

Sparks Dentistry

913 Ridgebrook Road Suite 206
Sparks, MD 21152
410-472-9650

Patient Registration

How did you find us? _____

Last dental visit? _____ Any current dental concerns? _____

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: ____
Address: _____ Address 2: _____
City, State, Zip: _____
Birth Date: _____ Soc. Sec: _____ Sex: __Male __Female
Marital Status: __Married __Single __Divorced __Separated __Widowed __Significant Other
Home Phone: _____
Work Phone: _____Ext: _____ ☐ **It is okay to contact me at the work # provided**
Cell Phone: _____
Email: _____

RESPONSIBLE PARTY *(ONLY if someone other than the patient)*

Relation to Patient:_____
First Name:_____ Last Name: _____ Middle Initial: ____
Address: _____ Address 2: _____
City, State, Zip: _____
Birth Date: _____ Soc. Sec: _____ Sex: __Male __Female
Marital Status: __Married __Single __Divorced __Separated __Widowed __Significant Other
Home Phone: _____
Work Phone: _____Ext: _____ ☐ **It is okay to contact me at the work # provided**
Cell Phone: _____
Email: _____

EMPLOYMENT INFORMATION

Employment/Student Status: ___Full Time ___Part Time ___Retired ___ Unemployed
Employer/School Name: _____

INSURANCE INFORMATION (*if applicable)*

Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder Soc. Sec. #: _____ Policy Holder Birth Date: _____
Insurance Company: _____
Insurance ID:_____ Group Number: _____

EMERGENCY CONTACT INFORMATION

Contact Person in case of emergency: _____ Phone number: _____
Relationship to patient: _____

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Medical History

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.

Please answer the following questions:

Are you under a physician's care now? ___YES ___NO If **YES**_____
Have you ever been hospitalized or had a major operation? ___YES ___NO If **YES**_____
Have you ever had a serious head or neck injury? ___YES ___NO If **YES**_____
Are you taking any medications, pills, or drugs? ___YES ___NO If **YES**_____
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? ___ Weeks?
___Taking Oral Contraceptives? ___Nursing?

ALLERGIES
___Aspirin Penicillin ___Codeine ___Local Anesthetics ___Acrylic ___Metal/Nickel ___Latex ___Sulfa
Other, please explain: _____

Do you have, or have you had, any of the following? PLEASE CHECK ALL THAT APPLY:

__AIDS/HIV Positive
__Alzheimer's Disease
__Anaphylaxis
__Anemia
__Angina
__Arthritis/Gout
__Artificial Heart Valve
__Artificial Joint
__Asthma
__Blood Disease
__Blood Transfusion
__Breathing Problem
__Bruise Easily
__Cancer
__Chemotherapy
__Chest pains
__Cold Sores/Fever Blisters
__Congenital Heart Disorder
__Convulsions
__Cortisone Medicine
__Diabetes
__Drug Addiction
__Easily Winded
__Emphysema
__Epilepsy or Seizures
__Excessive Bleeding
__Excessive Thirst
__Fainting Spells/Dizziness
__Frequent Cough
__Frequent Diarrhea
__Frequent Headaches
__Genital Herpes
__Glaucoma
__Hay Fever
__Heart Attack/Failure
__Heart Murmur
__Heart Pacemaker
__Heart Trouble/Disease
__Hemophilia
__Hepatitis A
__Hepatitis B or C
__Herpes
__High Blood Pressure
__High Cholesterol
__Hives or Rash
__Hypoglycemia
__Irregular Heartbeat
__Kidney Problems
__Leukemia
__Liver Disease
__Low Blood Pressure
__Lung Disease
__Mitral Valve Prolapse
__Osteoporosis
__Pain in the Jaw Joints
__Parathyroid Disease
__Psychiatric Care
__Radiation Treatments
__Recent Weight Loss
__Renal Dialysis
__Rheumatic Fever
__Rheumatism
__Scarlet Fever
__Shingles
__Sickle Cell Disease
__Sinus Trouble
__Spina Bifida
__Stomach/Intestinal Disease
__Stroke
__Swelling of Limbs
__Thyroid Disease
__Tonsillitis
__Tuberculosis
__Tumors or Growths
__Ulcers
__Venereal Disease

Have you ever had any serious illness not listed above? ___YES ___NO
If **YES**_____

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.

_____ _____
Patient/Guardian Signature **Date**

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Notice of Privacy Policy

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 Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

USES AND DISCLOSURES OF HEALTH INFORMATION
The following describes how information about you may be used in this dental office:

- **Treatment Services:** We may use or disclose your health information to all our staff members, other dentists, your physicians, and/or other health care providers taking care of you.
- **Payment and Health Care Operations:** We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
- **Marketing/Fundraising:** We will not use your health information for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.
- **Legal Requirements:** We may use or disclose your health information when required to do so by law.
- **Abuse or Neglect:** If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.
- **National Security:** When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may be provided to correctional institutes.
- **Family Members, Friends, and Others Involved in Care:** At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgement and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.
- **Business Associates:** Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

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- **Research:** We may use or disclose medical information to researchers when an institution's review board or special privacy board has reviewed the proposed study and established protocols to ensure the privacy of the health information used in their research and determined that the researcher does not need to obtain your authorization prior to using your medical information for research purposes.

- **Public Health Activities:** We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition; to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).

- **Other Authorizations:** In addition to our use of your health information for treatment, payment, or 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 authorization, you may revoke it at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was 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.

- **Breach Notification:** We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure.

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.
  We may charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there may be a fee for any copies of films in a form other than electronic. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. Details of all fees are available from the Office Manager.

- **Accounting of Disclosures:** 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. 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 will keep your information confidential from your health plans if you pay cash, at your request. In some instances, we may not be required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an 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 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 must explain the reason for the amendment.) We may deny your request under certain circumstances.

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Acknowledgement of Privacy Policy

Patient:

Parent/Guardian (for minor patients):

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Policy and have been given the opportunity to ask questions, make comments, or express any concerns.

I give my permission to Sparks Dentistry to share my health information with the following person(s):

Primary physician/office: _____ **Phone** #: _____

Specialist office: _____ **Phone** #: _____

Specialist office: _____ **Phone** #: _____

Personal Contact(s) Name and Relationship

1. _____/_____ **Phone** #: _____
2. _____/_____ **Phone** #: _____
3. _____/_____ **Phone** #: _____

_____ _____

Patient Signature: **Date:**

_____ _____

Parent/Guardian Signature: **Date:**

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FINANCIAL POLICY

Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

We accept payment in the following forms:

- Cash, Visa, MasterCard, or Discover- **WE DO NOT ACCEPT CHECKS**
- Convenient Monthly Payment Plans[1] from CareCredit

Payment Scheduling:

Sparks Dentistry requires payment at the time of treatment. Our office does our best to calculate your patient liability based on the information provided for us by your insurance carrier. In some instances, the insurance company may pay more or less than expected based on the information that they provided, and you may be responsible for the difference. Your insurance policy is a contract between you and your insurance carrier, and any questions regarding your coverage or patient liability should be directed to them. Please also be aware that we recommend and provide treatment based on patient need, not based on insurance coverage, and that you will be responsible for any treatment or procedure that you consent to if it is not covered by your insurance policy.

For procedures requiring multiple appointments, arrangements may be made to pay half at the first appointment, with the remainder due prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For large balances or procedures with large patient liabilities, Sparks Dentistry may offer payment plans. Please ask at the Front Desk for more information.

Cancellations:

Once an appointment is made, please remember this time has been reserved for you. All reminder calls and communications are done as a courtesy and you are responsible for keeping appointments that you have made. Below are the charges that will be made for repeated failed or cancelled appointments without prior notification of 24 hours.

- A fee of $45 is charged for patients who miss or cancel cleaning appointment without 24 hour notice.
- A fee of $100 per hour is charged for patients who miss or cancel any other type of appointment (filling, crowns, denture, root canal, etc.) without 24 hour notice

All balances, including for cancelled appointments, must be settled prior to rescheduling a cancelled appointment.

We send statements to any patients with balances monthly. If balance is not settled in full following three statements, Sparks Dentistry reserves the right to send the account to a third-party service for collections, and/or dismiss the patient from the practice.

_____

Patient, Parent or Guardian Signature: **Date**

_____

Patient Name (Please Print)

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APPOINTMENT POLICY

Sparks Dentistry is committed to providing you with the best possible care. As your dental provider, we want to help you understand and plan for your oral health. However, it is difficult for us to provide quality care when patients do not attend scheduled appointments.

Wait List

We do our best to have our patients scheduled in a timely fashion. In instances where you cannot get scheduled within your preferred timeframe, we are happy to place you on a wait list. When patients cancel, we send a text message to patients on our wait list with the date and time of the appointment. Appointments are filled on a first-come, first-serve basis.

Being placed on the wait list is not a guarantee of an appointment. To ensure that all our patients receive care, we recommend scheduling an appointment, even if it is not within your preferred timeframe, in case sooner appointments do not become available.

Cancellations

We understand that patients are sometimes unable to make their previously scheduled appointments. However, failing to give 24-hour notice makes it difficult, if not impossible, for us to offer cancelled appointment slots to other patients in need of treatment. Frequent cancellations without 24-hour notice or failure to show up to scheduled appointments may result in fees or dismissal from the practice.

- First Last-minute Cancellation or No-Show: No fee
- Additional Last-minute Cancellation or No-Show: $45 for cleanings, $100 for restoration/extractions

Patients may be dismissed from the practice following three last-minute cancellations or no-shows to an appointment within 18 months.

All last-minute cancellations or no-show fees MUST be paid in full prior to rescheduling the cancelled appointment.

Delinquent Accounts

We send statements to all patients with balances monthly. If balances are not paid after 90 days, accounts may be sent to a third-party collection agency or otherwise dismissed from the practice and all future appointments may be cancelled.

_____ _____

Patient/ Guardian Signature: **Date**

_____

Patient Name (Please Print):

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Agreement to Receive Electronic Communication

I _____ DO AGREE
I _____ DON'T AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

Our office also uses an automatic confirmation system to confirm all appointments. If for some reason, due to a technical difficulty, you do not receive a text(s)/ or email(s), **you are still responsible for the appointment that you schedule.**

I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

Mobile Phone: (_____) _____ - _____

Email: _____

(**NOTE**: If you do opt- out of the text reminders, you will not get any last minute/ same day reminders.)

Our appointment reminder and wait-list communications are only sent through text message. However, we will communicate all other information through your preferred method of communication:

_____ Phone
_____ Text
_____ Email

I can withdraw my consent to electronic communications at anytime by calling:

Sparks Dentistry, 410-472-9650 or at drnarlis@sparksdentistry.com

_____

Patient, Parent or Guardian Signature: **Date**

_____

Patient Name (Please Print)

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Authorization – Non-Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren).

This authorization gives the person permission to bring your child(ren) in and speak to the doctor

I, _____, give the person(s) listed below permission to bring my child to Sparks Dentistry and to discuss and share medical information about my child.

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____

(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE')

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Signature (Parent/Guardian) **Date**