WELCOME TO
SNOW HILL DENTAL ASSOCIATES

Child Registration

Child's Information

Date: ____________ Nickname: ____________

Child's First Name: ____________ Child's Last Name: ____________

Address: ____________ Address 2: ____________

City, State, Zip: ____________

Home Phone: ( ) ____________ Parent's Cell Phone: ( ) ____________

Sex: ☐ Male ☐ Female Date of Birth: ____________ Age: ________ Soc. Sec#: ____________

Parent's Information

Mother's Name: ____________

Father's Name: ____________

Address: ____________

City / State / Zip: ____________

Soc Sec#: ____________ Drivers Lic. #: ____________ Date of Birth: ____________

Employer: ____________ Work Phone: ( ) ____________ Ext: ________

Employer Address / City / State / Zip: ____________

How did you hear about our office? ____________

Person that referred you to our office? ____________

Preferred Pharmacy? (Please list pharmacy & location) ____________

In case of emergency, who should we notify? ____________ Phone Number: ( ) ____________

Dental Insurance Information

Name of Insured: ____________

Relationship to Patient: ____________ Birth date: ________ SS#: ____________

Name of Employer: ____________

Employer Address/ City/ State / Zip: ____________

Insurance Company: ____________

Insurance Address / City/ State/ Zip: ____________

Group #: ____________ Policy ID: ____________

Dental History

Date of last dental care? ____________ Date of last dental x-rays? ____________

Former dentist? ____________ Child's Favorite Toy, Hobby or Activity? ____________

Check (X) if your child has had or done any of the following :

☐ Thumb Sucking ☐ Pacifier Habit ☐ Takes Fluoride (tablets or rinse) ☐ Orthodontic Treatment

---OVER---

Medical History

Child's Name: ______________________________

Although dental personnel primarily treat the area in and around your child's mouth, your mouth is part of your entire body. Health problems that your child may have, or medication that your child may be taking, could have an important interrelationship with the dentistry they will receive. Thank you for answering the following questions.

Is your child under a physician's care now? ☐ Yes ☐ No Explain: ____________
Has your child ever been hospitalized or had major surgery? ☐ Yes ☐ No Explain: ____________
Has your child ever had a serious head or neck injury? ☐ Yes ☐ No Explain: ____________
Is your child taking any medications, pills, or drugs? ☐ Yes ☐ No Please List: ____________
Is your child on a special diet? ☐ Yes ☐ No ____________
Does your child use tobacco? ☐ Yes ☐ No ____________
Does your child use controlled substances? ☐ Yes ☐ No ____________

Women: Are you ☐ Pregnant ☐ Nursing? ☐ Taking oral contraceptives?

Is your child allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other ____________

Does your child have or had any of the following?

☐ 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 / Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack / Failure
☐ Heart Murmur***
☐ Heart Pace Maker***
☐ Heart Trouble / Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse***
☐ Pain in 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
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Has your child ever had any serious illness not listed above? ☐ Yes ☐ No

Comments: ____________

*** Condition may require medication

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 child's health. It is my responsibility to inform the dental office of any changes in my medical status.

____________ Print Child's Name ____________ Date

____________ Parent's Signature ____________ Date

Snow Hill Dental Associates

Master Academy of General Dentistry William F. Plack, III, D.D.S., M.A.G.D.

Please take the time to read over the following which will apply to your visit in our office. This is for your information and if you would like to request a copy for your records please let us know.

APPOINTMENT CANCELLATION POLICY: Appointments cancelled or broken with less then 24 hours notice will be subject to a minimum $50.00 charge with increases depending on the time allotted for the scheduled appointment.

PATIENT WITH DENTAL INSURANCE: We accept assignment from Delta Dental and Carefirst Blue Cross Blue Shield ONLY. Patients are responsible for any deductibles, co-payments, and non-covered service at the time service is provided. Any balance remaining unpaid after 45 days from the date of service will be due by the patient. We are urging the patient to check with your insurance company PRIOR to any treatment being performed. Please remember your insurance policy is between you and your insurance company.

PATIENT WITHOUT DENTAL INSURANCE: Payment is due at the time the service is provided unless other arrangements are made in advance. For extensive treatment, convenient payment plans are available with Care Credit which allows patients to space out payments as desired.

COLLECTION POLICY: There will be a $25.00 return check fee on all returned checks. Should collection be taken on an account, we shall be entitled to attorney's fees, court costs and interest on any unpaid balance.

PATIENT RECORDS: We are required to retain all original records. When provided with a written request, we will provide copies of patient records, including radiographs at the cost of 25% of the original, as provided by the Maryland Board of Dental Examiner's.

PATIENT PHOTOGRAPHS (CHILDREN ONLY): When photographs are taken I hereby authorize their use and permit the names of my children to be in the local paper for "No Kavity Klub".

SIGNATURE ON FILE: I authorize your office to maintain my signature on file for insurance purposes.

I have read and understand the above information

Patient's Name: ____

Signature: ____ _

(PARENT OR GUARDIAN MUST SIGN IF PATIENT IS A MINOR)

Date: ___________________________

Effective date of notice: April 2005
NOTICE OF PRIVACY PRACTICES
Dr. William Plack III, D.D.S., M.A.G.D.
303 North Washington Street
410-632-2551 or 410-632-2561 (fax)

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

* when a state or federal law mandates that certain health information be reported for a specific purpose;
* for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
* disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
* uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
* disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
* disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
* disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
* uses or disclosures for health related research;
* uses and disclosures to prevent a serious threat to health or safety;

* uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
* disclosures of de-identified information;
* disclosures relating to worker's compensation programs;
* disclosures of a "limited data set" for research, public health, or health care operations;
* incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
* disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

* ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office at the address, or fax us shown at the beginning of this Notice.
* ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office at the address, or fax us shown at the beginning of this Notice.
* ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office at the address, or fax us shown at the beginning of this Notice.
* ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can

have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office at the address, or fax us shown at the beginning of this Notice.

* get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office at the address, or fax us shown at the beginning of this Notice.
* get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office at the address, or fax us shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office at the address, or fax us shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone at 410-632-2551.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office at the address or phone number shown at the beginning of this Notice.

I acknowledge that I received a copy of Dr. William Plack III, D.D.S., M.A.G.D. Notice of Privacy Practices.

Patient Name ____

Signature ____ Date ____________________

Snow Hill Dental Associates

Master Academy of General Dentistry William F. Plack, III, D.D.S., M.A.G.D.

Financial Policy

We are aware that finances play a major role in whether a needed treatment is completed. With this in mind, we provide an array of financial options to better serve our patients.

1. We accept cash, personal checks (a $25 fee will be charged for returned checks) and credit cards (VISA, MasterCard or Discover) on all procedures.

2. Participating insurance:
   a. We participate with only Delta Dental Insurance, Blue Cross Blue Shield Traditional and PPO plans. As a courtesy, we file insurance claims on behalf of my patients for dental services performed in my office. It is important to remember that as your dentist I can only file claims on your behalf. The benefits belong to you, and it is up to you to ensure that you are receiving appropriate reimbursement under the terms of your plan.
   b. Read your dental plan benefits booklet carefully so that you fully understand the extent of your dental coverage. Dental insurance, unlike medical insurance, rarely covers the total cost of treatment. It is critical that you understand the treatments and procedures your plan includes, excludes and restricts. If you are unsure of any benefits to which you are entitled, consult your benefits manager or plan administrator.
   c. Some dental benefit plans require that the treatment plan be reviewed to determine whether the plan provides re-imbursement for the procedures before treatment starts. This will help you determine which services are your financial responsibilities. Before using your dental benefits, determine which services, if any, have to be preauthorized or predetermined by the carrier.
   d. ***Full payment of the deductible and co-payment is expected when services are rendered.***

3. Out of Network Insurance or No Insurance (Anything other then Delta Dental)
   a. We are not a provider for your dental insurance; we will no longer file your insurance claim for you at your office visit. As do the majority of dental and medical offices, **payment will be expected when services are rendered**. We will give you an itemized claim form at the end of your visit so that you can file the claim with your insurance company at your convenience. Although we will do everything possible to insure the correctness of your claim, the benefits belong to you and it is your responsibility to insure that you are receiving appropriate reimbursement under the terms of the plan.

4. We also offer a "NO INTEREST" and fixed interest payment plan through Care Credit. To qualify, simply call 800-365-8295 or go online at www.carecredit.com A credit report will be done, evaluating your credit history and once approved you may begin treatment as soon as possible.

5. Multiple visit procedures, such as crowns, inlays, bridges, laminates and dentures, may be paid in 2 payments- with the first payment (1/2) due at onset of treatment and the second payment (1/2) due when inserted/completed.

303 N. Washington Street, P. O. Box 86 Snow Hill, Maryland 21863-0086

(410) 632-2551 snowhilldentalassociates@msn.com Fax (410) 632-2561

Snow Hill Dental Associates

Master Academy of General Dentistry — William F. Plack, III, D.D.S., M.A.G.D.

What does MAGD stand for after your general dentist's name?

Your dentist is a member of the Academy of General Dentistry (AGD), an organization of general dentists who are dedicated to professional development and continuing education. All AGD members must remain current with advances in the profession to provide quality patient treatment. A general dentist who has earned the designation "Master" of Academy of General Dentistry (MAGD) has completed a structured and rigorous set of requirements involving all the dental disciplines. Masters have accepted the charge to keep abreast of advances in dentistry for the benefit of patients and betterment of dentistry. They serve as mentors and leaders to other dentists pursuing continuing dental education. They set examples in their communities with their hard work, concern and involvement.

What are the requirements for Mastership in the Academy of General Dentistry?

To attain Mastership, members must first be Fellows in the Academy of General Dentistry (Fellowship requires a minimum of 500 approved continuing dental education credits and passage of a comprehensive 400 question examination). Then they must earn an additional 600 approved continuing dental education credits, meeting minimum requirements in certain dental disciplines, of which 400 hours are hands-on or participation courses. Thus, a Master of the Academy of General Dentistry has taken a total of 1,100 hours of continuing dental education. A Master has studied 16 disciplines in dentistry such as periodontics, endodontic, orthodontics and implants.

What is special about a dentist who has an award from the Academy of General Dentistry?

Masters of the Academy of General Dentistry continue in a lifelong pursuit of continuing dental education to provide the highest quality of dental care to patients. The award symbolizes the professional responsibility of general dentists to remain current in their profession and reminds each member of the dental profession to continue to learn new techniques for their dental practice. These are awards, however, and should not be confused with post graduate degrees or certification (Dr. Plack has completed both a 1-year and 2-year Advanced Education in General Dentistry Program). Every dentist who applies for the Mastership award has their application reviewed by the AGD Council of Dental Education to assure that the high standards of the Academy of General Dentistry are met.

How many dentists have achieved Mastership?

To date (February, 1997), more than 1,000 Academy of General Dentistry Fellows have gone on to receive Mastership. The Academy is very proud of all of its members who must take 75 hours of continuing dental education every three years and especially proud of its members who have made the commitment to pursue this award. When your dentist has achieved the Mastership Award, you can be assured that they are dedicated to providing the finest care in general dentistry.

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Snow Hill Dental Associates

Master Academy of General Dentistry William F. Plack, III, D.D.S., M.A.G.D.

Office Appointment Policy

A medical or dental office has two commodities that can be offered to patients. First, there is the expertise and clinical skills of the health care provider. Second, there is time specifically a limited number of minutes and hours each week that is available for patient care.

When you are given an appointment for dental care in our office, you are actually reserving a previously identified amount of time. That time, whether it is 10 minutes or 2 hours, it is time that has been set-aside for you and only you. When that time is lost because of a late cancellation or failure to show up, that time is lost not only to you but also to other patients who could of have used that time for their care.

As do other health care offices, we have a policy that requires at least 48 hours notice to cancel or change a scheduled dental appointment. This policy gives us the time to reschedule another patient for that time so that your treatment time is not lost to others. As do other offices, we reserve the right to charge a failed-appointment fee up to $75 if you do not show up for your dental appointment or you cancel your appointment with insufficient time for us to fill it with another patient. If that appointment is a multiple one or more then 1 hour in length, we reserve the right to increase this fee accordingly. We will make every attempt to call you 2 days prior to your appointment to remind you of the date and time of your appointment. If we leave a message on your answering machine, we ask that you return our call to let us know that you received the message. In that regard, it is essential that we have a current, correct phone number.

Because you and your dental care are important to us, every effort will be made to not only facilitate the scheduling of the time necessary for your care but also to insure that you are seen on time.

Please be assured that we value you as a patient and as such, we fully realize that situations and circumstances arise which are impossible to foresee and plan for. As our policy is not written in stone, the decision to assess a fee will be made on an individual basis.

If you should have any questions regarding this policy or its implementation, please do not hesitate to ask one of the office staff.

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