



1984 Isaac Newton Sq. W. #100 Reston, VA 20190 703.437.5555 www.myrestondentist.com

Patient Information

_____ Patient's Last Name	_____ First Name	_____ Middle Initial	_____ Preferred Name
_____ Responsible Party's Name (if not patient)	_____ Relationship to the patient	_____ Today's Date	
Family Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
_____ Street Address	_____ City	_____ State	_____ Zip
_____ Home Phone Number	_____ Cell Number	_____ Work Number	
_____ Social Security Number	_____ Date of Birth	_____ Email Address	
_____ Employer (School)	_____ Occupation (Field of Study)		

Primary Insurance Information

_____ Subscriber Name	_____ Subscriber SSN		
Is insured a patient: <input type="checkbox"/> yes <input type="checkbox"/> no	Relationship of Patient to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
_____ Subscriber Date of Birth	_____ Group Number	_____ ID Number	
_____ Subscriber Street Address (if different from above)	_____ City	_____ State	_____ Zip
_____ Subscriber's Employer Name	_____ Insurance Company/ Plan Name		

Secondary Insurance Information

_____ Subscriber Name	_____ Subscriber SSN		
Is insured a patient: <input type="checkbox"/> yes <input type="checkbox"/> no	Relationship of Patient to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
_____ Subscriber Date of Birth	_____ Group Number	_____ ID Number	
_____ Subscriber Street Address (if different from above)	_____ City	_____ State	_____ Zip
_____ Subscriber's Employer Name	_____ Insurance Company/ Plan Name		

Cosmetic Information

- yes no Are you happy with the appearance (color, size, shape) of your teeth?
- yes no Is there anything about your smile that you do not like? If no, please describe.

- yes no Are any of your teeth chipped or missing?
- yes no Do you have any old fillings or dental treatment that you are unhappy with?
- yes no Are your teeth crowded or crooked?
- yes no Have you whitened your teeth in the past?
- yes no Are you interested in options available for a beautiful smile?

Is there anything else you would like us to know about your dental health or interested in hearing about? _____

Medical History

- yes no Do you smoke?
- yes no Have you been admitted to the hospital or needed emergency care within the last 3 years? If so
Why? _____
- yes no (For women only) Are you pregnant? If yes, how far along? _____
- yes no Are you currently under the care of a physician?

Physician Name Physician Phone Number
- yes no Are you currently taking any medications? Please list below:

- yes no Have you ever premedicated with antibiotics prior to a dental appointment?
If yes, what did you premedicate for? _____
- yes no Are you allergic to anything? _____

Please check if you have/had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS /HIV | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough (Persistent) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Fainting/ Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever/ Allergies | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Problems | |

“To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is ever a change in my health or the health of my minor child, I understand it is my responsibility to inform the doctor at my next appointment without fail.”

Signature of patient, parent or guardian

Date

Cancellation Policy

Please review and sign below:

To make sure that every patient gets individual attention, we set aside dedicated time for each appointment. Our staff spends time meticulously preparing for each appointment by sterilizing, organizing and arranging the set up items prior to your arrival. This ensures that we achieve the high standard of care and treatment we pride ourselves on. We understand that interruptions to schedules occur and we appreciate that everyone is subject to issues of family, health, and emergencies of multiple proportions. However, our time is scheduled in order to focus upon your oral health concerns.

If you find it necessary to cancel or reschedule an appointment, we require that you provide us with at least 48 business hours notice.

Patients who cancel or reschedule their reserved appointment without prior notice will be assessed a \$75.00 fee to offset the lost production time and estimated amount of time and effort the staff has already spent preparing for the appointment.

Name of Patient or Representative (please print) Date: _____

Signature of Patient or Representative Date: _____



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Consent for Services

Please review, initial and sign below:

_____ As a condition of my treatment by Reston Family and Cosmetic Dentistry, financial arrangements must be made in advance. All emergency dental services or any dental service performed without previous financial arrangements must be paid for at the time services are performed.

_____ I understand that all dental services are charged to me and that I am responsible for the payment of all dental services. I understand that as a courtesy, Reston Family and Cosmetic Dentistry will help to prepare my insurance forms or assist in making collections from insurance companies and will credit any such collections to my account. However, the office cannot render services on the assumption that the charges will be paid by an insurance company.

_____ I understand that a returned or declined check is subject to a non-refundable processing fee of \$50.00.

_____ I agree to a service charge of 1½% per month (18% per annum) on any unpaid balance exceeding 60 days, unless previously written financial arrangements have been made.

_____ In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

"I have read the above conditions of treatment and payment and agree to their content in its entirety."

Name of Patient or Representative (please print)

Date: _____

Signature of Patient or Representative

Date: _____



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Notice of Privacy Practices (HIPAA)

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

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 your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 20, 2007 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 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 HEALTH INFORMATION

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

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

Payment: We may use and disclose your 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 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 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 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.

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 or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose 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, your general condition, or death. If you are present, then prior to use or disclosure of your 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 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 marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are 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 or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized 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 health 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).

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 \$0.10 for each page, \$20 per hour for staff time to locate and copy your health information, and postage if you 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 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 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 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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 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 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.

Privacy Officer: Monica Neshat, DDS
1984 Isaac Newton Sq. W. #100
Reston, VA 20190
703.437.5555

“I acknowledge that I have read and received a copy of the Notice of Privacy Practices and understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information as described in the “Notice of Privacy Practices.”

_____ Date: _____
Name of Patient or Representative (please print)

_____ Date: _____
Signature of Patient or Representative

****You May Refuse to Sign This Acknowledgement****

