



Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender: Male Female Family Status: Married Single Divorced Separated Child Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

_____ City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | Due date: _____ | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors | |

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

 Signature of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Divorced Separated Child Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

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 understand that I must notify this office 48 hours prior to my appointment time for any cancellations. Failure to do so will result in a broken appointment fee of \$75.00.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian

Date: _____

Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Date: _____

Relationship to Patient: _____



Cosmetic Information

Is there anything about your smile that you do not like? _____

Are you happy with the appearance (color, size, shape) of your teeth?

Are your teeth crowded or crooked? _____

Are you missing any teeth? _____

Are any teeth chipped? _____

Is your bite comfortable when chewing, biting? _____

Does food get trapped between your teeth when you eat? _____

Do you have frequent headaches, neck pain and/or shoulder aches?

Do you have any old fillings or dental treatment that you are unhappy with?

What would you like to change the most about the appearance of your teeth?

Are you interested in the options available for a more beautiful smile?

Have you ever whitened your teeth? _____

Is there anything else that you would like us to know? _____

NOTICE OF PRIVACY PRACTICES

RESTON FAMILY AND COSMETIC DENTISTRY

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 Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how our health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested

restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate you for filing a complaint.

Please contact us for more information:

Reston Family & Cosmetic Dentistry
1984 Isaac Newton Square W. #100
Reston, VA 20190
703.437.5555

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
202.619.0257
Toll Free: 877.696.6775



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a
copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign**
- Communication barriers prohibited obtaining the acknowledgement**
- An emergency situation prevented us from obtaining acknowledgement**
- Other (please specify) _____**