PATIENT INFORMATION

CONFIDENTIAL

NAME _____
FIRST MI LAST

DATE OF BIRTH _____ SSN _____

GENDER: ☐ MALE ☐ FEMALE

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ OTHERS

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER: (HOME) _____ (CELL) _____ (WORK) _____

EMAIL ADDRESS _____

PREFERRED CONTACT METHOD? HOME PHONE / CELL PHONE / WORK PHONE / EMAIL

PATIENT OR PARENT'S EMPLOYER _____ OCCUPATION _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ SPOUSE OR PARENT'S SSN _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME _____ PHONE NUMBER _____ RELATIONSHIP _____

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ INTERNET, PLEASE CIRCLE: GOOGLE / YAHOO / YELP / BING / ZOCDOC / FACEBOOK / WEBSITE / OTHER_____

☐ INSURANCE COMPANY

☐ MAGAZINE/NEWSPAPER AD

☐ FRIEND/FAMILY MEMBER: IF SO, NAME OF PERSON _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

RELATIONSHIP TO PATIENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER: (HOME) _____ (CELL) _____

DATE OF BIRTH _____ SSN _____

EMPLOYER _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

DENTAL INSURANCE

DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO

IF YES, ARE YOU THE MAIN SUBSCRIBER? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

SUBSCRIBER NAME _____
FIRST MI LAST

SUBSCRIBER'S DATE OF BIRTH _____ SUBSCRIBER'S SSN _____

EMPLOYER _____

X _____

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS WITHIN THE LAST 6 YEARS? IF YES, PLEASE EXPLAIN. _____	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____	☐	☐
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL?	☐	☐
6. DO YOU USE CONTROLLED SUBSTANCES?	☐	☐

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS, FOOD OR METALS? IF YES, PLEASE SPECIFY. _____

	YES	NO
8. ARE YOU TAKING ANY MEDICATION TO PREVENT OSTEOPOROSIS?	☐	☐
9. DO YOU HAVE DRY MOUTH?	☐	☐
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

11. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

☐ HIGH BLOOD PRESSURE	☐ SEIZURES/EPILEPSY/CONVULSIONS	☐ SHORTNESS OF BREATH	☐ ARTHRITIS
☐ LOW BLOOD PRESSURE	☐ DIABETES	☐ EASILY BRUISE	☐ JOINT REPLACEMENT/IMPLANT
☐ FAINTING	☐ ANEMIA/LEUKEMIA	☐ LIVER DISEASE	☐ IMMUNE DISEASES
☐ HEART ATTACK	☐ HAY FEVER/ALLERGIES	☐ HEPATITIS/JAUNDICE	☐ AIDS OR HIV INFECTION
☐ PROSTHETIC HEART VALVE	☐ GLAUCOMA	☐ KIDNEY DISEASES/DIALYSIS	☐ SEXUALLY TRANSMITTED DISEASE
☐ CARDIAC PACEMAKER	☐ ORGAN TRANSPLANT	☐ TUBERCULOSIS	☐ CANCER
☐ RHEUMATIC FEVER	☐ THYROID PROBLEM	☐ ASTHMA	☐ CHEMO/RADIATION THERAPY
☐ SWOLLEN ANKLES	☐ STROKE	☐ FREQUENTLY COUGH	☐ RECENT WEIGHT LOSS
☐ HEART MURMUR	☐ STOMACH TROUBLES/ULCERS	☐ EMPHYSEMA/BRONCHITIS	☐ DEPRESSION/ANXIETY/PHOBIA
☐ ANGINA/CHEST PAIN	☐ EXCESSIVE BLEEDING	☐ RESPIRATORY PROBLEM	☐ SCHIZOPHRENIA/BIPOLAR
☐ OTHER			

_____

_____

PATIENT DENTAL HISTORY

ARE YOU HAPPY WITH YOUR TEETH AND YOUR SMILE? ☐ YES ☐ NO

IF YOU COULD CHANGE ANYTHING ABOUT YOUR TEETH OR SMILE, WHAT WOULD IT BE? _____

_____

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN/NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
(A) CLICKING?	☐	☐
(B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
(C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
(D) DIFFICULTY IN CHEWING?	☐	☐

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOU LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
13. HAVE YOU HAD ANY ORTHODONTIC TREATMENT?	☐	☐
14. HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS?	☐	☐
15. DO YOU HAVE NUMBNESS IN THE FACE/MOUTH?	☐	☐

I certify that I have read and understand the above information, to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN IF MINOR DATE

TYSONS DENTISTRY
(703) 442-0770

FINANCIAL POLICY

Our dental office accepts most major PPO dental insurances for your convenience. Dental benefits are not meant to determine your dental care; they are to assist you in the payment of your treatment. As a courtesy to all patients, we do our best to verify your dental insurance benefits, but ultimately you will be responsible to know your benefits. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by my insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or my dependents (if any). We accept cash and most major credit cards. All balances over 60 days are subject to interest in amount of 1.5% per month. Our office offers CARE CREDIT payment plan for your convenience. Your appointments are considered confirmed as soon as they are made. If for any reason you cannot keep your scheduled appointment or will be delayed, please contact our office 48 hours in advance to reschedule. If you need a copy of your dental records, you will need to request that in writing. Our office need to receive your written request at least 24 hours in advance to prepare your record to be transferred.

- **I agree to pay the charges for services at the time of treatment.**
- **All returned checks are subject to $25 fee.**
- **In the event of a broken appointment, or cancellation with less than 48 hours notice, a fee of $100/hour of appointment will be charged to your account.**
- **A $25 administrative fee will be applied for record transfer.**

I have read and understand the above information. I acknowledge that I am responsible for all charges and past due balances on my account/ my dependent, in addition to collection costs. I understand my payment is due at the time of treatment.

Patient Name _____ Date _____

Signature (of patient/Legal Guardian) _____

TYSONS DENTISTRY

(703) 442-0770

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
□ First Name Only □ Proper Surname □ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):
Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

□ Cell Phone Confirmation
□ Home Phone Confirmation
□ Work Phone Confirmation
□ Text Message to my Cell Phone
□ Email Confirmation
□ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

□ Cell Phone Confirmation
□ Home Phone Confirmation
□ Work Phone Confirmation
□ Text Message to my Cell Phone
□ Email Confirmation
□ **Any of the Above**

I GIVE PERMISSION TO HAVE PHOTOGRAPHS OF MY DENTAL WORK POSTED WITHIN OUR DENTAL PRACTICE AND/OR ON OUR WEBSITE, SOCIAL MEDIA ACCOUNTS, VIDEOS OR SLIDE SHOWS PRESENTATIONS TO EDUCATE PATIENTS AND PROMOTE OUR DENTAL PRACTICE. IDENTITY WILL BE CONFIDENTIAL:

□ YES □ NO

I hereby certify that I have read and understand the patient information, dental/medical history forms and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, photographs, study models, or other diagnostic and perform such diagnostic procedures as may be necessary for proper dental care.

I acknowledge that I have received a copy of the Notice of Privacy Practices for this healthcare facility. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____	_____	_____
Please ***print*** name of Patient	Please ***sign*** for Patient / Guardian of Patient	Date
_____	_____	_____
Legal Representative / Guardian	Relationship of Legal Representative / Guardian	Date

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Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

□ It was emergency treatment
□ I could not communicate with the patient
□ The patient refused to sign
□ The patient was unable to sign because
□ Other (please describe) _____

Signature of Privacy Officer