DULLES DENTAL GROUP

Name _____ ☐ Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms
Last First MI

Date of Birth _____ Age _____ Who may we thank for referring you? _____

Reason for your visit _____

Social Security # _____ Home Phone _____ Business Phone _____ Cell Phone _____

E - mail _____ Which one do you prefer us to use as primary point of contact:☐ Home Phone ☐ Cell Phone ☐ Business Phone ☐ E-mail

Home Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Spouse's Name _____

Spouse's Employer _____ Spouse's Social Security # _____ Legal Guardian _____

Dental Insurance ☐ Yes ☐ No If yes, Insurance Co._____ Group # _____

Policy Holder _____ Date of Birth _____ Employer _____

Employer address and phone _____ ID # _____

Relationship _____ If you are not the policy holder, your Member ID # _____

Contact in case of emergency _____ Relationship _____ Phone _____

Please check those conditions that now are or have ever pertained to you

YES	NO		YES	NO	
☐	☐	Heart Murmur or Congenital Heart Defect	☐	☐	Do you smoke
☐	☐	Heart Surgery or Heart Disease	☐	☐	Are you pregnant
☐	☐	Rheumatic Fever	☐	☐	Headaches
☐	☐	Mitral Valve Prolapse	☐	☐	Recent weight loss
☐	☐	Heart Pacemarker	☐	☐	Chemical dependency
☐	☐	Abnormal Blood Pressure ☐ High ☐ Low	☐	☐	Dizziness or Fainting Spells
☐	☐	Bleeding Problems	☐	☐	Strokes
☐	☐	Diabetes	☐	☐	Lung Problems or Tuberculosis
☐	☐	Joint Replacement	☐	☐	Thyroid disease
☐	☐	Convulsions or Seizure	☐	☐	Glaucoma
☐	☐	Hepatitis ☐ A ☐ B ☐ C	☐	☐	Ulcers
☐	☐	Venereal Disease	☐	☐	Arthritis
☐	☐	HIV +	☐	☐	Kidney Disease
☐	☐	Herpes	☐	☐	Blood Disease, i.e, Anemia
☐	☐	Cancer	☐	☐	Sinus Trouble
☐	☐	Radiation or Chemotherapy	☐	☐	Jaundice or Liver Disease
☐	☐	Do you have a snoring problems	☐	☐	Are you taking Birth control pills

Other medical problem not listed above? _____

List any medication you are currently taking and the reason _____

_____

Are you allergic or sensitive to:

YES	NO		YES	NO	
☐	☐	Penicillin	☐	☐	Local Anesthetics like Novocain
☐	☐	Aspirin	☐	☐	Other Drugs or Medicines (list) _____
☐	☐	Codeine	☐	☐	Food (list) _____

Name of Physician _____ Phone _____ Date of last physical _____

Name of your former Dentist _____ Phone _____

When was your last visit? _____ What was done at that time? _____

Date of last Professional Dental Cleaning _____

YES	NO		YES	NO	
☐	☐	Are you teeth sensitive to sweet? Temperature?	☐	☐	Do your gums bleed or have pain?
☐	☐	Do you notice popping in your jaw?	☐	☐	Do you clench or grind your teeth?

PERMIT FOR TREATMENT

This is to certify that I, undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I willassume responsibility for fees associated with those procedures.

Patient or Guardian Signature _____ Date _____

DULLES DENTAL GROUP

WELCOME TO DULLES DENTAL GROUP

We appreciate you choosing us to meet your dental needs. We take this responsibility seriously and our highly-qualified staff ready to accommodate you during your reserved appointment time.

Appointment Commitment

Please review the following:

If unforeseen circumstances occur which make it necessary for you to change your scheduled appointment, we request that you give us at least two business days notice.
A broken appointment, one in which a patient does not call or show up, there may be a fee of 30.00 per missed appointment, per provider, per half hour.

_____(Initials) I agree to the above terms

Financial Policy

In order to provide our patients with the highest quality dental care on a sound business basis, we provide estimates of fees. Patient, parent and/or guardian are responsible for the patient portion on the date of service. This is not your insurance company's responsibility. **We will file all necessary claims to your insurance as a courtesy to you**. It is the patient's responsibility to contact their insurance companies if their claim remains unpaid within 45 days from the date of service. Any balance beyond 45 days is the patient's responsibility, and interest will be applied at a rate of 1.5% per month.

Financial options that we provide at this time:

Cash or check on date of service treatment.
5% reduction on patient portion over 500.00 if paid prior to treatment with **cash or check only.**
Major credit card (American Express, Discover, MasterCard, Visa).
Extended payment plan (based on credit approval).
5% Senior Citizen courtesy (age 65 and over).

It is patient's responsibility to complete treatment and follow recommended maintenance schedule. If the treatment and maintenance plans are not followed and/or appointments are missed, adverse results could affect your dental health. If the treatment plan is not followed in a timely manner, additional treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints might become necessary.

_____(Initials) I agree to the above terms

Insurance Policy

Importance of patient awareness regarding insurance benefits:

Dulles Dental Group realizes the importance of insurance benefits. We ask patients to carefully review their policies and/or contact their insurance carriers with doubts about the terms of their coverage: benefits, frequencies, allowances, limitations, maximums and/or restrictions. Please be informed that dental insurance is a contract between patients and their insurance companies. Ideal Dental Solutions is pleased to provide the courtesy of assisting patients in filing their claims. Our dentist's focus and dedication is aimed at providing the highest quality of care, independent of the terms of your insurance coverage. Patients are encouraged to take the time to learn the extent of their coverage, and this office will make any effort to help you to make your dental needs and financial needs come into alignment. Your insurance mails a copy of an Explanation of Benefits (EOBs) to you. Please pay attention to these statements. Check your policy for a dental deductible and whether your insurance pays at a percentage or by their allowed fee schedule. We will ask you for a copy of your insurance card and benefit booklet (if available) at your first visit or at the time of dental coverage changes. **It is your responsibility to provide us with any future changes in your insurance**. If any dental services have been provided with any other provider within the existing benefit year, please advise us as well. Providing us with your Social Security number is required for accounting purposes, if you choose to do not provide the SSN the full payment is required at the time of service.

_____(Initials) I agree to the above terms

I understand and agree to the aforementioned, and I acknowledge that I am responsible for any/all remaining balance on my account not covered by insurance. _____ (Initials)

Patient or Guardian Signature _____ Date _____

DULLES DENTAL GROUP

CONSENT AGREEMENT

Though it is not necessary to have your consent to allow us to use or disclose your individually identifiable health information (IIHI) to others who will treat you or support in providing you quality health care services, it is important to have your consent to use or disclose your IIHI to health care plans to insure accurate and timely payments for the services rendered. The law requires that we inform you of our policy regarding the protection of your IIHI through or Privacy Notice.

Thank you for your confidence in our practice and for supporting our requirements.

I, _____, have been presented with a Privacy Notice explaining my right regarding my individually identifiable health information (IIHI). I consent to the disclosure of my IIHI for purposes of treatment, payment, release of X – Ray or other health care operations to those individuals that I have listed bellow:

- Name _____ Relationship _____
- Name _____ Relationship _____
- Name _____ Relationship _____
- Patient's Name (if under 18) _____ Relationship _____

Acknowledgement of Receipt of Privacy and Practices

** You may refuse to sign this acknowledgement**

I, _____, have received a copy of this office's privacy notice and Practices.

Patient or Guardian Signature _____ Date _____

THIS SECTION FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy notice and Practices.

- ○ Obtained signature and acknowledgement of "acceptable individuals to release IIHI to" form.
- ○ Individual refused to sign.
- ○ Emergency situation prevented the patient from receiving information during initial visit.
- ○ Communication barrier prohibited release of IIHI and acknowledgement of agreement.