

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred name)
 Male Female Married Single Child Other _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____
 Email: _____
 Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of last dental visit: _____ Reason for today's visit: _____

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

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

Are you allergic to or have you reacted to any of the following medications?

- | | | | | | |
|---------------|--|------------------|--|--------------|--|
| Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No | Erythromycin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Darvon | <input type="checkbox"/> Yes <input type="checkbox"/> No | Local Anesthetic | <input type="checkbox"/> Yes <input type="checkbox"/> No | Valium | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nitrous Oxide | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tetracycline | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Percodan | <input type="checkbox"/> Yes <input type="checkbox"/> No | Codeine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfa | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you ever taken any of the following medications?

- | | | | | | |
|---------|--|---------|--|--------|--|
| Actonel | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fosamax | <input type="checkbox"/> Yes <input type="checkbox"/> No | Zometa | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Aredia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Reclast | <input type="checkbox"/> Yes <input type="checkbox"/> No | Boniva | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you require antibiotic pre-medication for previous heart infections, heart defects, replacement heart valves or joint replacements (i.e. hip, knee)? Yes No

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

• Please list all medications: _____

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: _____

Responsible Party Information

The following is for: the patient's spouse the insurance policy holder self, same as previous page

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Employment Information

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

Employer Name: _____ Occupation: _____

Dental History

Please check all of the following problems that apply to you

Sensitivity (hot, cold, sweet, pressure)

Headaches, earaches, neck pain

Jaw joint pain

Broken teeth or fillings

Grinding or clenching teeth

Bleeding, swollen or irritated gums

Loose or shifted teeth

Bad breath

Snoring

Do you smoke or use chewing tobacco? Yes No

- How much? _____ For how long? _____

Please share the following dates:

- Your last cleaning ____/____

- Your last oral cancer screening ____/____

- Your last x-rays ____/____

Name of your previous dentist: _____

City: _____ State: _____

Phone number: _____

Referral Information

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

Dental Office Yellow Pages Newspaper School Work Other _____

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

Consent for Services

The undersigned hereby authorizes Reston Dental Care to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor make a thorough diagnosis of the patient's needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____

Dentist Signature

Reston Dental Care
11345 Sunset Hills Road
Reston, VA 20190
Tel (703) 689-0110 Fax (703) 467-8030
<http://www.restondental.com>

Financial Agreement

As a courtesy to our patients, we will help you process your insurance claims. All insurance information must be provided as requested to aide in filing your claims. It is your responsibility as the insured to understand your dental policy. We must emphasize that our relationship is with you, our patient, not with your insurance carrier. Any assistance with insurance matters granted by the doctor(s) will be given strictly as a courtesy and implies no responsibility by the doctor or his/her staff for filing claims, following through after claims have been filed or confirmation of benefits. You may direct your insurance company to pay benefits directly to our practice by signing the authorization on the assignment of benefits agreement line below. Your **estimated** co-payment for treatment is provided. Your **estimated** co-payment may be adjusted after the time of treatment depending upon final reconciliation of insurance payments. All chargers you incur are your responsibility regardless of your insurance coverage.

I understand that while Reston Dental Care participates with **most** PPO insurance carriers, that **Joseph L. Richardson DDS does not** participate with any insurance plans and is an **Out-Of-Network Provider**.

I, the undersigned, hereby agree to reimburse Reston Dental Care the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs, and expenses, including reasonable attorneys' fees, Reston Dental Care may incur in such collection efforts. Interest will be computed at the rate of 1% per month (12% per annum) on all account balances beginning 30 days after the monies have become due. I agree to pay returned check charges of \$25.00 per returned check.

Reston Dental Care reserves the right to charge \$75 to \$100 for appointments canceled or broken without 24 hours advance notice.

I agree that this financial agreement will remain in full force and effect until revoked by me in writing and receipt acknowledged in writing by Reston Dental Care.

Name: _____ Date: ____/____/____

Signature of Responsible Party: _____

Assignment of Benefits Authorization: **I hereby authorize my insurance company to pay any allowable dental benefits directly to Reston Dental Care/EA Dental, PLLC.**

Signature of Insured: _____

Date: ____/____/____

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

A detailed Notice of our office Privacy Practices is available upon request.

The following summary outlines how our office will protect your health information, your rights as a patient and our common practices in dealing with your health information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please submit your concerns in writing to:

Katie Landolfi
11345 Sunset Hills Road
Telephone No. (703) 689-0110

Reston Dental Care
11345 Sunset Hills Road
Reston, VA 20190
Tel (703) 689-0110 Fax (703) 467-8030
<http://www.restondental.com>

HIPAA Acknowledgement

PURPOSE: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. You may refuse to sign this acknowledgement.

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

(print name)

(signature)

Authorization to Release Information

PURPOSE: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

(print name)

(relationship)

(print name)

(relationship)

(print name)

(relationship)

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)
