Patient Information

Today's Date:_____

Patient Name: _____
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:

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

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

Aspirin	☐ Yes ☐ No	Latex	☐ Yes ☐ No	Erythromycin	☐ Yes ☐ No
Darvon	☐ Yes ☐ No	Local Anesthetic	☐ Yes ☐ No	Valium	☐ Yes ☐ No
Nitrous Oxide	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No
Percodan	☐ Yes ☐ No	Codeine	☐ Yes ☐ No	Sulfa	☐ Yes ☐ 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 under the care of a physician or have any other health problems? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever taken a class of drugs called **Bisphophonates or Anti-RANKL**, commonly used to treat ***bone conditions (such as osteoporosis)*** and cancers? ☐ Yes ☐ No
  If yes, please explain: _____

  Examples include but not limited to:
  Actonel or Atelvia (risedronate), Aredia (pamidronate), Binosto or Fosamax (alendronate), Boniva (ibandronate), Didronel (etidronate), Miacalcin (calcitonin), Reclast or Zometa (zolendronic acid), Skelid (Tiludronte), Prolia or Xgeva (denosumab)
- 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.

_____ Date: _____
Signature of patient, parent or guardian

Responsible Party Information

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

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? _____

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.

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

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

_____
Dentist Signature

Reston Dental Care

Modern, Gentle Dentistry

1801 Robert Fulton Dr. Suite #300
Reston, VA 20191
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, 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:

Reston Dental Care
1801 Robert Fulton Dr. Suite #300
Telephone No. (703) 689-0110

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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)

_____
_____