TYSONS
ELITE DENTAL

We are pleased to welcome you and your family to our practice. Please take a few minutes to fill out this form to the best of your ability. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your overall oral health.

PATIENT INFORMATION

Patient Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____Email: _____

Home Phone: _____ Work: _____ Cell: _____

Occupation: _____ Employer: _____

Do we have your permission to contact you by text or email? YES or NO

MARITAL STATUS (PLEASE CIRCLE): SINGLE MARRIED DIVORCED WIDOWED

Social Security # (required)_____Date of Birth: _____

Emergency Contact: _____ Phone: _____

Who should we thank for referring you to our office? _____

RESPONSIBLE PARTY – IF SAME AS ABOVE PLEASE SKIP

Full Name:_____ Cell: _____

Address: _____ Relationship to Patient _____

City: _____ Social Security # (Required) _____

State: _____ Zip: _____ Date Of Birth: _____

DENTAL INSURANCE

PRIMARY: Medical Dental

Insurance Company: _____

Subscriber's name: _____

Relationship to subscriber: _____

Insurance ID #: _____

Group #: _____

Address: _____

City: _____

State: _____ Zip: _____

Insurance Phone #: _____

SECONDARY: Medical Dental

Insurance Company: _____

Subscriber's name: _____

Relationship to subscriber: _____

Insurance ID #: _____

Group #: _____

Address: _____

City: _____

State: _____ Zip: _____

Insurance Phone #: _____

DENTAL/MEDICAL HISTORY

Reason for visit today: _____

Date of last dental visit: _____ Date of last X-Rays: _____

Name of former dentist: _____

Have you had any major surgery in the last 2 years? YES NO

Due to a medical condition, do you **PREMEDICATE?** YES NO

Please list any prescribed medications you are currently taking: _____

_____

_____

Do you have any allergies/sensitivities? **PENICILLIN CLINDAMYCIN LATEX EPINEPHRINE CODEINE**

Other: _____

Are you pregnant? YES or NO How many weeks? _____ Are you breastfeeding? YES or NO

Please circle to indicate if you have had any of the following:

Aids/HIV	Glaucoma Head Injuries	Mental Disorder	Swollen Ankles
Angina	Hearing Aids/Deaf	Nervous Disorder	TMJ/TMD
Asthma	Heart Attack, Failure, Disease	Pacemaker	Vision Problem
Blood Disease	Heart Surgery/Condition	Periodontal Disease	Thyroid
Breathing Problems	Heart Murmur/MVP	Radiation Treatment	Tuberculosis/TB
Cancer	Hepatitis: A, B, C	Respiratory Problems	Transplants
Diabetes	High Blood Pressure	Rheumatic Fever	Tobacco Use
Artificial Joints	Seizures	Sickle Cell	Chronic Cough
Sinus Problem	Jaundice/Liver Problem	Epilepsy	Leukemia
Stroke	Other: _____		
	Please Explain: _____		

Please circle your selection:

Are your happy with your smile?	YES	NO
Are you happy with the color of your teeth?	YES	NO
Are you interested in straightening your teeth?	YES	NO
Do any of your teeth hurt?	YES	NO
Do you grind or clench your teeth?	YES	NO
Is your bite giving you trouble?	YES	NO
Do your gums bleed while brushing or flossing?	YES	NO
Do you use an electric toothbrush?	YES	NO
Do you experience a bad taste in your mouth?	YES	NO

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Acknowledgment of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among several healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment form third-party payers for my healthcare services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of my dental provider's NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such NOTICE OF PRIVACY PRACTICES.

I understand that my dental provider has the right to change the NOTICE OF PRIVACY PRACTICES and that I may contact this office at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Dependent family member also covered by this acknowledgement: _____

Relationship to Patient: _____

Signature X: _____

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Financial Policies

YOUR SIGNATURE AT THE BOTTOM OF THIS PAGE INDICATES THAT YOU UNDERSTAND AND AGREE TO OUR FINANCIAL POLICIES

Full payment is due at the time services are rendered.

FOR PATIENTS WITH INSURANCE:
We do accept assignments of your insurance benefits; however, we do require that your co-payment and deductible be paid in full at the time of your appointment. The balance is your responsibility whether your insurance pays for your treatment or not. In the event that your insurance does not pay as much as we anticipate, you are responsible for the remaining balance. It is imperative that you inform us of any changes in your insurance coverage **PRIOR TO TREATMENT**.

Although we will be happy to assist you in any way we can, your insurance policy is a contract between you, your employer, and the insurance company, and you are responsible for knowing your benefits. Please be aware that some, or perhaps all, of the services provided may not be covered (or may be considered at an alternate benefit). If there is a problem with your insurance company, we will try to help.

KEEPING APPOINTMENTS:
Your appointment is a block of time that is especially reserved for your dental care. Please arrive 10 minutes before your scheduled appointment time. A late arrival jeopardizes the time available for your visit and our ability to be on time. Patients arriving 10 minutes late or more to an appointment may have to reschedule the appointment.
For the consideration of your doctors and fellow patients, we require at least 48 BUSINESS hours' advance notice to change an appointment. Failure to provide the required 48-hour notice will incur a $75 charge.

Any claims unpaid within 60 days of the date of service become the patient's responsibility.

- Payment may be made via Cash, Check, Discover, MasterCard or Visa.
- A charge of $75 may be applied to your account for broken appointments, unless a 48-hour (Business Hours) notice is given.
- There is a $30 +$5 bank fee for all returned checks.

If my account goes to a third party for collection, I understand that I will be responsible for any fees involved in the collection process. This includes but is not limited to court costs and attorney fees in addition to the outstanding balance.

Printed Name: _____ Date: _____

Signature X: _____

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Consent for Treatment

We make every effort to provide service and quality dental care for you so that you can treat and maintain your health as quickly, efficiently and as affordable as possible. I have a personal and ethical responsibility to care for your health to the best of my ability.

I, _____ consent to be a patient at the above-named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my Dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results. I understand that the Dentist reserves the option to alter treatment. These changes may increase the fees, I do not require to be notified if fees are lower than anticipated.

4. I will pay in full for any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for any costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.