ADVANTAGE
DENTAL CARE

7022 Commerce Street, Suite A
Springfield, VA 22150
703-644-9786

PATIENT INFORMATION:

Patient Name: _____ Preferred Name: _____

Birth Date: _____ Male ☐ Female ☐ Minor Y N

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____

E-mail address: _____

Emergency Contact: _____ Phone #: _____

Other family members seen by us? _____

PARENT INFORMATION (ONLY IF PATIENT IS A MINOR):

Name: _____ Relationship to patient: _____

Birth Date: _____ Male ☐ Female ☐

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

DENTAL INSURANCE:

Policyholder's Name: _____ DOB: _____ SS/ID #: _____

Insurance Company: _____ Group #: _____

Employer: _____

Patient Relationship to policyholder: Self ____ Spouse ____ Child ____

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WOMEN: Are you or could you be pregnant? Y N Are you Nursing? Y N Taking Oral Contraceptives? Y N

Are you currently being treated for or have you ever been treated for any of the following? Please only circle the ones that apply:

AIDS/HIV	Cortisone Treatments	Jaundice	Stroke
Anemia	Cough, persistent or bloody	Jaw Pain	Tonsillitis
Arthritis	Diabetes	Kidney Disease	Tuberculosis
Artificial Heart Valves	Down Syndrome	Liver Disease	Thyroid Disease
Asthma	Emphysema	Low Blood Pressure	Psychiatric Care
Autism	Epilepsy	Mitral Valve Prolapse	Ulcer
ADHD	Fainting or dizziness	Pacemaker	Venereal Disease
Back problems	Glaucoma	Radiation Treatment	
Blood Disease	Headaches	Respiratory Disease	
Cancer	Heart Murmur	Rheumatic Fever	
Chemical Dependency	Heart Surgery	Scarlet Fever	
Chemotherapy	Hepatitis Type_____	Sinus Trouble	
Circulatory Problems	Herpes	Swollen Neck Glands	
	High Blood Pressure		

Other: _____

Are you allergic to any of the following? PLEASE CIRCLE YES or NO FOR EACH ONE:

Latex Y N Penicillin Y N Aspirin Y N Sulfa Y N Dental Anesthetics Y N Codeine Y N

Other**:** _____

Please list all medications you are currently taking: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform the office of any changes in my medical status.

Patient Signature: _____ Date: _____

Parent/Guardian Signature **if patient is a minor:** _____ Date: _____

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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.

Date: _____

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

_____ _____

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Last Name ☐ 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: _____

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

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APPOINTMENT POLICY

Your appointment time is reserved just for you. If you are unable to keep your appointment, please let us know 48 hours in advance, failure to do so will result in a fee of $50 for any missed appointment. The missed appointment fee must be paid prior to future office visits.

(Please Initial)_____

CONSENT FOR DENTAL PROCEDURES

I hereby request and authorize the dentist at First Family Dental and the dentist's auxiliaries to perform all dental treatment and surgery as indicated in my dental records and treatment plan. I understand and authorize for these procedures, which are deemed necessary and advisable in the dentist's judgment. I also authorize the administration of drugs and anesthetics, as may be deemed advisable by the dentist.

COUPONS & SPECIALS

On occasion, our practice offers discounts or coupons to help make dental care more affordable for non-insurance holding patients. Our $79 special is structured to help assist patients that obtain routine dental care every 6 months in maintaining optimal dental care. The $79 special covers a complete exam, simple cleaning, and 4 bite wing x-rays.

This offer is not valid for patients who are diagnosed with periodontal disease by the dentist, as these patients require an intensive deep cleaning; a simple cleaning will not help and is not sufficient for the patient's oral health. The doctor will not perform the simple cleaning in these instances .

(Please Initial) _____

DENTAL INSURANCE

Dental insurance is a contract between the employer and the patient. It has **NO CONNECTION** to the provider of dental treatment. The extent of the coverage varies from company to company, and sometimes even within a company.

Although it is not required, as a courtesy, we will prepare and submit your insurance claim forms at no cost to you. At your request, we might also provide estimates that show the expected insurance reimbursement and patient share for every procedure. This is only an **estimate**.
You are ultimately responsible for the cost of all professional services rendered, regardless of estimate, if insurance does not pay their portion.

In the event that we have services of an outside collection agency to obtain payment, you will be responsible for all fees charged to our practice by the collection agency.

I fully understand my financial obligation and responsibility to adhere to the appointment policy.

Patient Signature or Parent/Gaurdian signature if patient is a minor:_____

Date: _____ Name: _____

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DENTAL HISTORY

Reason for today's visit: _____

_____

_____

Former Dentist: _____

City/State: _____

Date of last dental visit: _____

Date of last dental X-rays: _____

Place a mark on 'yes' or "no" if you have any of the following.

Bad Breath: Yes☐ No ☐

Bleeding Gums: Yes☐ No☐

Blisters on lips or mouth: Yes ☐ No☐

Cigarette, pipe cigar smoking: Yes☐ No☐

Chewing tobacco: Yes☐ No☐

Clicking or popping jaw: Yes☐ No☐

Dry mouth: Yes☐ No☐

Build-up between teeth: Yes☐ No☐

Grinding teeth: Yes☐ No☐

Gums swollen or tender: Yes☐ No☐

Loose teeth or broken fillings: Yes☐ No☐

Pain when brushing: Yes☐ No☐

Orthodontic treatment: Yes☐ No☐

Periodontal treatment: Yes☐ No☐

Sensitivity to cold: Yes☐ No☐

Sensitivity to heat: Yes☐ No☐

Sensitivity to sweets: Yes☐ No☐

Sensitivity when biting: Yes☐ No☐

Sores or growths in mouth: Yes☐ No☐

How often do you floss?

_____

How often do you brush?

_____