



WELCOME TO OUR OFFICE. PLEASE TAKE A MOMENT TO ENTER YOUR INFORMATION TO HELP US ENSURE THE QUALITY OF YOUR CARE IS EXCELLENT. WE LOOK FORWARD TO WORKING WITH YOU

Hometown Dental Care

Patient Information

Name :(Last, First, MI) _____ Preferred Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: _____ Age: _____ Sex: M F SSN: _____ Family Status: Single/ Married/ Divorced/ Widowed
Phone: () _____ Cell Phone: () _____ Best time to call: _____
Driver License No: _____ Email: _____ Employer/Occupation: _____
Employer Address: _____ Whom may we thank for referring you to our practice? _____
In case of emergency, contact: _____ Relationship: _____

Primary Dental Insurance

Name of Subscriber :(Last, First, MI) _____ Relationship to patient: _____
Address (if different from Patient's): _____ City: _____ State: _____ Zip: _____
Subscriber's Date of birth: _____ Subscriber ID: _____ Group #: _____
SSN: _____ Employer Name: _____ Employer Address: _____

Secondary Dental Insurance

Name of Subscriber :(Last, First, MI) _____ Relationship to patient: _____
Address (if different from Patient's): _____ City: _____ State: _____ Zip: _____
Subscriber's Date of birth: _____ Subscriber ID: _____ Group #: _____
SSN: _____ Employer Name: _____ Employer Address: _____

Insurance Authorization:

By checking this box,

I authorize my insurance to pay my benefits directly to the dentist for all services rendered.

I authorize this practice to submit insurance claim forms and receive payment directly from the insurance carrier with the notation "signature on file"

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges, whether or not paid by insurance.

Patient/ Parent or Guardian Signature: _____ Date: _____

Dental Information

What is the reason for this appointment? _____

What is your immediate concern? _____

Date of most recent dental exam/ x-rays: _____

Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10 (most) _____

How would you rate the condition of your mouth? Excellent Good Fair Poor

Check all that apply:

- | | | |
|---|---|---|
| <input type="radio"/> Have you ever whitened your teeth? | <input type="radio"/> Problems with your jaw joint | <input type="radio"/> Problems chewing |
| <input type="radio"/> Clench your teeth during the daytime /nighttime | <input type="radio"/> Cavities within past 3 years | <input type="radio"/> Sensitive to hot, cold, sweets |
| <input type="radio"/> Gums bleed easily when brushing or Flossing | <input type="radio"/> chronic bad breath or bad taste | <input type="radio"/> Suffer from snoring & sleep apnea |
| <input type="radio"/> Experienced burning sensation in Your mouth | <input type="radio"/> Trouble getting numb | <input type="radio"/> had/ have braces, orthodontic treatment |

If any of the checked circles need further explanation, please describe:

How often do you brush? _____ How often do you floss? _____

Do you suffer from snoring & sleep apnea? _____ If yes, please fill out "Epworth Sleepiness Scale" form.

Patient Treatment Consent

By checking this box, I authorize the Dentist (s) treating me or my dependents to perform recommended treatment and procedures. I understand that during treatment, unforeseen conditions may arise which may necessitate procedures different from those discussed prior to treatment. I therefore consent to the performance of any additional treatment which the dentist considers necessary and mutually agreed by me.

Patient/ Parent or Guardian Signature: _____ Date: _____

Medical History

To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Indicate which of the following you have had or have at present. Please check all that apply.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Any heart problems | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Mitral valve prolapsed | <input type="checkbox"/> Heart valve defect |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Angina | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Bypass | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Any bleeding disorders | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Sickle cell trait | <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Do you smoke? | <input type="checkbox"/> Lung/breathing problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Difficulty in healing | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Adrenal/ pituitary problems |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Hepatitis/ Jaundice | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach trouble/ ulcers |
| <input type="checkbox"/> Nervous or mental Disorders | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Cancer/ Tumor | <input type="checkbox"/> Other growths | <input type="checkbox"/> Chemo/ radiation therapy | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Other infectious Disease | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Are you pregnant? | <input type="checkbox"/> Are you nursing? |

Allergic reaction (hives/swelling) to: (check all that apply)

- | | | | | |
|--|---------------------------------------|--|----------------------------------|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Codeine | <input type="checkbox"/> Nickel or other metals |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex | <input type="checkbox"/> Local Anesthetic (Novocain) | | |
| <input type="checkbox"/> Other Medications or Substances? Please list: _____ | | | | |

If any condition or alert selected above needs further clarification, please explain below:

Do you need to take antibiotic pre-medication prior to dental appointments? Yes No **Name of Antibiotic:** _____

Are you currently under a physician care? _____ For what reason: _____

Physician's name, address and phone number: _____

Are you presently taking any medications, pills, or tonics? (i.e., Blood pressure, birth control, steroids, hormones) Yes No

Medication	For	Medication	For

I certify that the above information is complete and accurate to the best of my knowledge. I will inform the dentist of any changes in my health status or my medications.

Patient/ Parent or guardian signature: _____ Date: _____

Doctor signature: _____ Date: _____

Patient Smile Evaluation Form

Name: _____

Date: _____

To help diagnosis and create a treatment plan based off of your concerns, please take a moment and answer the following questions. Please circle your answer.

Do you dislike the color of your teeth?

YES ___ **NO** ___

Do you have spaces between your teeth that bother you?

YES ___ **NO** ___

Do you have chips or uneven edges on your teeth?

YES ___ **NO** ___

Do you feel that your teeth are too long or too short?

YES ___ **NO** ___

Do you have dark fillings that show when you smile?

YES ___ **NO** ___

Do your gums show too much when you smile?

YES ___ **NO** ___

Are your teeth crowded or crooked?

YES ___ **NO** ___

Do you have existing crowns or dental work you consider “ugly”?

YES ___ **NO** ___

Are you self-conscious of your teeth and/or smile?

YES ___ **NO** ___

Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile?

YES ___ **NO** ___

Do you avoid smiling when you have your picture taken?

YES ___ **NO** ___

Would you like to improve your existing smile?

YES ___ **NO** ___

Do you wish you had a “new smile”?

YES ___ **NO** ___

Please checkmark next to which of the following are concerns you have regarding dental treatment to improve your smile:

Fear of treatment:

Time of treatment concerns:

Financial concerns:

Distance to office:

Not understanding treatment:

Embarrassment:

Other:

Epworth Sleepiness Scale

Name: _____ Date: _____

Your age (yrs) _____ Sex: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0=would **never** doze

1=**slight chance** of dozing

2=**moderate chance** of dozing

3=**high chance** of dozing

Situation	Chance of Dozing (0-3)
Sitting and reading _____	
Watching TV _____	
Sitting, inactive in a public place (e.g. a theatre or a meeting) _____	
As a passenger in a car for an hour without a break _____	
Lying down to rest in the afternoon when circumstances permit _____	
Sitting and talking to someone _____	
Sitting quietly after a lunch without alcohol _____	
In a car, while stopped for a few minutes in the traffic _____	

HOMETOWN DENTAL CARE

Arezou Daneshvar, DDS

**821 S. King Street, Suite E
Leesburg VA 20175**

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of *HOMETOWN DENTAL CARE HIPAA Notice of Privacy Practices*.

I understand that *HOMETOWN DENTAL CARE, HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of *HOMETOWN DENTAL CARE revised HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about *HOMETOWN DENTAL CARE HIPAA Notice of Privacy Practices*, I may contact Dr. Arezou Daneshvar.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that *HOMETOWN DENTAL CARE* will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding *HOMETOWN DENTAL CARE* privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Dr. Arezou Daneshvar noted above, for assistance.

_____	_____
Patient Signature	Date
_____	_____
Signature of Personal Representative	Print Name of Personal Representative

	Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

HOMETOWN DENTAL CARE made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, *HOMETOWN DENTAL CARE* was unable to obtain a signed Acknowledgement for the following reason(s):

- Refusal to sign Acknowledgement on _____, 20____.
- Communications barriers prohibited us from obtaining a signed Acknowledgement.
- An emergency situation prohibited us from obtaining a signed Acknowledgement.
- Other (Describe): _____

Date Received	By	Patient ID

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practice provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

YES___ NO___

May we leave a message on your answering machine at home or on your cell phone?

YES___ NO___

May we discuss your medical condition with any member of your family?

YES___ NO___

If **YES**, please name the members allowed:

This consent was signed by: _____

(PRINT NAME PLEASE) _____ Date: _____

Doctor Signature: _____ Date: _____

Witness: _____ Date: _____



HOMETOWN DENTAL CARE

DR. AREZOU DANESHVAR

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OFFICE POLICY

WELCOME

Dr. Arezou Daneshvar graduated from West Virginia University in 2004. After graduation, Dr. Daneshvar worked for various private practices and for several free dental clinics that provided dental services for the underserved patients. In July of 2017 Dr. Daneshvar opened her own practice “**HOMETOWN DENTAL CARE**”.

MISSION STATEMENT

My mission is to provide quality dental care that exceeds all expectations of my patients. I believe in keeping my community healthy. I am committed in providing my patients cutting edge services, information and knowledge they will need to achieve and maintain their best dental health. I will personalize your dental needs for the treatment you deserve.

APPOINTMENTS

All appointments are scheduled for when you the patient is available. Confirmation of appointments is provided as a courtesy and is not guaranteed. Please contact the office prior to your appointment with any updated changes such as insurance and/or contact information.

CANCELLATIONS

“**HOMETOWN DENTAL CARE**” knows that your time is valuable as is ours. In an effort to provide uninterrupted care to each patient, we do not over book any appointments unless it is a true dental emergency. If you are 15 or more minutes late your scheduled appointment, we may need reschedule so not interfere with the following patient’s appointment. **HOMETOWN DENTAL CARE** requires a 48hrs notice of cancellation or a broken appointment fee of **\$50** may be charged.

FINACIAL

ALL PAYMENTS ARE EXPECTED AT TIME OF SERVICE THAT INCLUDES ANY INSURANCE DEDUCTIBLES AND COPAYS. For your convenience we accept cash, checks, debit and credit cards. **IF CHECKS ARE RETURNED DUE TO INSIGNIFICANT FUNDS, A RETURNED CHECK FEE OF \$25 WILL BE CHARGED.** If you have dental insurance we will process your dental claims as a courtesy. All “**ESTIMATED**” copays are not a guarantee of insurance payment. We do encourage you, the patient, to contact your insurance company directly with any questions concerning your coverage.

EMERGENCIES

HOMETOWN DENTAL CARE is always available to see our patients for any true dental emergency during regular business hours and occasionally after regular business hours. **WE PRIDE OURSELVES IN PROVIDING THE BEST DENTAL CARE FOR OUR PATIENTS.**

Patient’s Name/Minor

Date

Patient’s Signature/Guardian

Date