WELCOME TO LEESBURG SPA DENTISTRY

Name: _____ Date of Birth: _____

SS#: _____
Address (No PO Box): _____City_____ Zip Code: _____
Age: _____ Sex: _____ Marital Status: _____ Email Address: _____
Home# _____ Cell # _____
Full Time Student: _____ Name of College: _____

How did you hear about our office: Please Circle
Flyer in the mail Your insurance Google from a friend? Who: _____

**If a friend comes in and lists you as the person who referred them, you will receive a special gift from us. Thank you in advance!

PRIMARY DENTAL INSURANCE INFORMATION

Policy holder: _____ Relationship to Patient: _____

Birthdate: _____ Social Security #: _____

Name of the dental Insurance: _____ Phone # _____

Member ID# _____ Group# _____

Name of Company employed at: _____

It is the patient's responsibility to make sure their insurance is current and keep the office updated with any changes so that we may file on your behalf. We will call your insurance as a courtesy but will not do pre- authorizations.

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____
Cell Phone #: _____ Email: _____
Home #: _____

I authorize and request my insurance company to pay Leesburg Spa Dentistry directly. I understand that I am responsible for any denied and/ or unpaid portion of my dental claim. Payment is due in Full at the time of service. I also authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to the Third-Party Payers and Health Practitioners. I understand that Leesburg Spa Dentistry complies with all HIPPA policies and regulations and I may request a detailed outline of such policies.

_____ _____

Print Name of responsible party Signature of Patient or Guardian

PATIENT MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: _____ Phone # _____
Date of last Exam: _____ Height: _____ Weight: _____Blood Pressure:_____
Have you ever been told you have one of the followings? Please circle

Heart Disease Anemia Asthma Heart Murmur Joint replacement/Implant Bleeds Easily AIDS/HIV

Swollen Ankles Cancer Stroke Arthritis Chest pain (Angina) Heart Attack

Fainting Seizures Hay Fever Diabetes 1 High blood pressure

Low blood pressure Epilepsy/convulsions Shortness of breath Leukemia Stomach Ulcer

Thyroid Disease Glaucoma Kidney Disease Liver Disease Jaundice Hepatitis

Emphysema Rheumatic Fever Psychiatric Treatment Radiation Therapy STD

Congenital heart defect Mitral Valve Prolapse Seasonal Allergies Diabetes 2

Other: _____
Do you have any allergies to medications? _____
Yes or No:
____ Did you get the COVID vaccine? _____ If yes when? _____
____ Are you under any medical treatment now? Explain_____
____ Have you ever had any serious illness not listed above? Explain_____
____ Are you on WELL water?
____ Have you ever had any bad reaction to anesthetics? Explain_____
____ Do you use tobacco? How often: _____
____ Do you consume alcohol? How often: _____
____ Do you use cocaine or other drugs not prescribed?_____
____ Are you pregnant or think you could be? Are you taking birth control? _____
List ANY medications you are currently taking:
_____
_____
_____

Dental History
What is the reason for your visit? _____
How many times do you floss per day? _____ How many times do you brush? _____
Do you clench or grind your teeth? _____ Do you bite your cheeks frequently? _____
Have you ever worn braces? _____ Do you wear Dentures? _____ Partials? _____
Have you every had any trauma to your face or mouth? _____
Do you have any sores or lumps in or around your mouth? _____
Do you have any discomfort or pain now? _____
Do your gums bleed when brushing? _____
I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____ _____
Patient's Name Signature of patient or Guardian Date

_____

FINANCIAL POLICY

Thank you for choosing Leesburg Spa Dentistry as your dental care provider. Our office is committed to providing you with the highest quality dental care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

If you have UMR, we are unable to verify your insurance coverage. You will be responsible for making sure you are still active and pay any balances not covered by your insurance.

Payment Options:

Your insurance policy is a contract between you and your insurance company. We are not part of the contract. As a courtesy to all patients, we will verify your dental coverage, but you are responsible to know your plan coverage, exclusions, and limitations. **We do not do Pre-authorizations**. If your insurance company doesn't pay the estimated portion, it will be your responsibility to pay the difference with in 30 days. **Nitrous Oxide**: This is also known as "laughing gas", can be used to relax a patient when they are feeling anxious. If this is something you would like, please let us know when you are scheduling so we can have you in the appropriate room. The fee is $180

BOOKING TREATMENT: To reserve your time with the Doctor, we do require half payment down of treatment scheduled. On the day of your reserved time we will collect the other half before you are seen. We do this to insure all patients are able to receive their treatment in a timely manner.

RESIN-BASED COMPOSITE RESTORATION (FILLING): Most dental insurance plans do not allow full benefits for composite fillings (white) performed on posterior teeth (back molars). The plan benefit will customarily pay upon a silver filling and you pay the difference between the two. To provide our patients with the longest lasting dental treatment we do not do Amalgam (silver) fillings.

An After- Hours Fee- If the Doctor is made to come in the office for an emergency appointment when the office is closed a fee of $200 will be applied in addition to the services rendered upfront.

MISSED APPOINTMENT FEE: Leesburg Spa Dentistry does charge a missed appointment fee of $50 per half hour of your appointment time if not given a 48hour Business notice

CHARGES: All return checks are subject to a $35 fee. We reserve the right to apply a $25 late fee for any over due payment for each month the balance goes unpaid. We will report your overdue balance to any credit agency or credit bureau we choose. _____ Initial

PAST DUE PAYMENTS: Any accounts over 90 days past due will be turned over to a collection agency or attorney; you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs, expenses including reasonably attorney's fees, we incur in such collection efforts. With past due balances all family members in the chart are held responsible. If one person in the chart has a credit we may use that to pay some of the balance owed to the office. _____ Initial

TRANSFERRING RECORDS: We do require you to fill out an x-ray release form when requesting x-rays. The charge is $50 per patient. We do require 48 hours to process your request to any patient or dental office. If you would like a complete record you will have to email the Doctor and allow 1 week for processing at the charge of $200 per patient. _____ Initial

Thank you for understanding the Financial Policy. I have read and will follow the office policies. All of my questions have been answered to my satisfaction.

Patient signature: _____

PLEASE HANDLE ME WITH CARE…

What is most important to you about your overall health?

_____

What is important to you in your relationship with your health care provider?_____

_____

Please circle the number next to the statement that concerns you or fits you:

1. I have not been to the dentist for a long time and I feel worried about what you will say about my teeth
2. My teeth are very sensitive
3. I am very anxious about injections
4. I gag easily
5. I hate the noise of the dental instruments
6. I hate the sight or smell of the dental office
7. Pain relief is a top priority for me
8. I feel out of control in the dental chair or have extreme problem with lying down
9. I hate my smile
10. I am happy with my smile
11. I don't like to see all the details, x-rays, pictures etc. it makes me nervous. Just explain.
12. I have bad breath
13. My gums bleed when I floss or brush them
14. I have had gum treatment done in the past
15. I don't like the color of my teeth

Anything else we can do to make your dental experience great?

_____

_____

_____