# RESTON DENTAL CENTER Health History and Registration

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Have you ever taken	DATIFATIC NAME Loss		PATIENT INF		Initial	CEV: M E	PIDTUD/	ATE.	AGE	
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ASSECTION STORMS Street										
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CELL PHONE   CELL PHONE   Would you like to receive dental care reminders via Took Reseaping? Yes No										
RESPONSIBLE PARTY INFORMATION  NAME Last  RESPONSIBLE PARTY INFORMATION  PRIVATE CAP  Apt # City State 2p  Apt # City State 2p  Apt # State 2p  Apt # City S										
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RESIDENCE Street  Apt # City State Zip  Apt # City State Zip  MARTAL STATUS  Apt # City State Zip  MORE PHONE  CELL PHONE  CELL PHONE  CELL PHONE  DENTAL INSURANCE INFORMATION (Primary Carrier)  Insured's Rome  Insured's R	EWAIL	you like	to receive dentary	care reminders vi	ia Text Messagi	ng: 103_	110		S. F. S. S.	
ARE DEN CASES Street  ARE DIV State ZB DEN CASES Street  ARE DIV State ZB DEN CASES Street  ARE DIV State ZB DEN CASES STREET  BURNER DOWN SCHURTY # BURNER DOWN STATE STREET  BORNER SCURITY # BURNER DOWN STATE STREET  BORNER SCHURTY # STATE STATE STREET  BORNER SCHURTY # STATE STREET  BORNER SCHURTY # STAT						ial	N	IADITAL STATUS		
MALLING ADDRESS Singel  Agt # City State Zo  WORK PHONE  WORK PHONE  BIRTHOATE  COCUPATION  BIRTHOATE  COCUPATION  COCUPATION  NO. YEARS EMPLOYED  DENTAL INSURANCE INFORMATION (Primary Carrier)  Insured a Name  Insured a N										
EMAIL  SOUTH FINDS  BIRTHDATE  DRIVERS LICENSE # RELATION TO PATIENT  BIRTHDATE  DRIVERS LICENSE # RELATION TO PATIENT  DRIVERS LICENSE # RELATION TO PATIENT  Insured So. Soc. # PHONE  Insured Soc. Soc. # PHONE  Insured Soc. Soc. # PHONE  Insured Soc. Soc. # Group # Local # Insured Soc. * Group # Loca										
BODIAL SECURITY # BIRTHOATE DRIVERS LICENSE # RELATION TO PATIENT  DENTAL INSURANCE INFORMATION (Primary Carrier) Insured s Name Insurance Co. PHONE Insured S Name Insurance Co. Address Insured S Robert Insured										
DENTAL INSURANCE INFORMATION (Primary Carrier)  Insurance Co. Address Insurance Co. Addr		PHONE_			WORK I	PHONE				
DENTAL INSURANCE INFORMATION (Primary Carrier) Insured 5 Name Insured 5 Name Insured 6 Co. PHONE Insured 6 Employer Insured 5 E						-				
DENTAL INSURANCE INFORMATION (Primary Carrier)   If you have additional dental insurance coverage, complete this for the secondary carrier.   Insurance Co. Address   Insured s Rame   Insurance Co. Address   Insured s Employer   Insured s										
Insurance Co. PHONE	EMPLOYER		OCCUPA	TION			NO. YI	EARS EMPLOYED	10000000	
Insurance Co. PHONE	DENTAL WOULDANGE INFORMATION (P.	_		f you have additio	nal dental incura	200 00000720	o complet	a this for the secondary	carrie	or.
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Insured's Employer Insured's Employer Insured's Employer Insured's Soc. Sec. # Group # Local #  It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.  DENTAL HISTORY VES NO HOW CONG SINCE you have seen a dental?  Do you have any CURRENT HEALTH PROBLEMS?  Last FULL MOUTH X-RAYS, DAYE: (18 small Plins or Panoramic)  Are you under a PHYSICIAN'S CARE now? If yes for what?  Last FULL MOUTH X-RAYS, DAYE: (18 small Plins or Panoramic)  Have you wort taking a PHYSICIAN'S CARE now? If yes for what?  Last FULL MOUTH X-RAYS, DAYE: (18 small Plins or Panoramic)  Have you under a PHYSICIAN'S CARE now? If yes for what?  Do you shave place the strict of t										
It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.  DENTAL HISTORY YES NO MEDICAL HISTORY YES NO HOW LONG SINCE you have seen a dential?  Last COMPLETE Dential Exam, Date:  Any you whave any CURREMT HEALTH PROBLEMS?  Any you whave any CURREMT HEALTH PROBLEMS?  Any you whave them Fars. Pheric Redux Commending  Any you present dental health POOR?  Do you use agreeding seet the you with your dentures?  PLEASE YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:  Yes NO Open upon any ELECTOR WHICH YOU HAVE HAD, OR PRESENTLY HAVE:  Yes NO Open upon any ELECTOR Pheric Redux Commending  Any your PREFERENT Book of the TRINGER OR RITIKITED?  Any your PREFERENT Book of the TRINGER OR RITIKITED?  Any your PREFERENT BOOK AND										
It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.  DENTAL HISTORY  YES NO  MEDICAL HISTORY  YES NO  DO you used you currently taking?  DO you used you currently taking?  DO you used gensted never in your dentity taking?  DO you used gensted never in your dentity taking?  DO you used gensted never in you currently taking?  DO you used gensted never in you currently taking?  DO you used gensted never in you currently taking?  DO you used gensted never in you currently taking?  DO you used gensted never in you currently taking?  DO you used gensted never in you currently taking?  DO you used gensted never in you currently taking?  PLASEY YES NO NO PTHE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:  YES NO PTHE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:  YES NO PTHE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:  YES NO PTHE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:  Have you wanted pour level with your dentities presponsible for expension your present your treating the your use have you currently taking?  PROBLEM TO A THE YOU HAVE HAD, OR										
is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.    Destal History   YES NO   MEDICAL HISTORY   YES NO   YE	Insured's Soc. Sec. # Group #	Local #		nsured's Soc. Sec. #	#		_ Group # .	Local#		
Last COMPLETE Denial Exam, Dale:  Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panonamic)  Have you use taken  What MEDICATIONS are you currently taking?  What MEDICATIONS are you currently taking?  Do you need to premedicate?  Do you used DESTURES? (Partials or Full)  Do you used classified particles pipe or chewing tobacco? (circle)  Are you UNIAPPY with your dentures?  Do you used DESTURES? (Partials or Full)  Do you used Classified Particles pipe or chewing tobacco? (circle)  Are you UNIAPPY with your dentures?  Do you used DESTURES? (Partials or Full)  Do you used Classified Particles pipe or chewing tobacco? (circle)  Are you UNIAPPY with your dentures?  Do you used Classified Particles pipe or chewing tobacco? (circle)  Are your DESTURES? (Partials or Full)  Do you used DESTURES? (Partials or Full)  Do you used Classified Particles pipe or chewing tobacco? (circle)  Are your DESTURES? (Partials or Full)  Do you used Classified Particles pipe or chewing tobacco? (circle)  Are your DESTURES? (Partials or Full)  Are your DESTURES? (Partials or Full)  Are your DESTURES? (Partials or Full)  Are your DESTURES. (Par	is strictly confidential and will not be release  DENTAL HISTORY  YES	ed to	anyone. Thank	you for taking	the time to c	ompletely			e. YES	NO
Are you ward personal content the beath POOR?  De you need to premedicate?  De you need to premedicate?  De you ward DENTURES? (Partials or Full)  De you ward DENTURES? (Partials or Full)  De you use class/cigarettes, pipe or chewing tobacc? (circle)  De you ward DENTURES? (Partials or Full)  Are you UNHAPPY with your dentures?  PLEASE YES ON 00 FTHE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:  VIS NO AppREHENSIVE about dental treatment?  Anaphylaxis  Anaphylaxis  De your gums BLEED, or feel TENDER or IRRITATED?  Anaphylaxis  Anthritis (Rheumatism)  Arbitis (Rheumatism)  Arbitis (Rheumatism)  Headaches  Arbitis (Rheumatism)  Headaches  Arbitis (Rheumatism)  Heart problems (please describe)  Shortness of breath  Artificial joints  Are you ware of GRINDING or CLENCHING your teeth?  Do your aware of GRINDING or CLENCHING your teeth?  Do your have HEADACHES, CARACHES, or NECK PAINS?  Do you have HEADACHES	Last COMPLETE Dental Exam, Date:		Are you under a PHY	SICIAN'S CARE now	v? If yes for what?					
Syour present dental health POOR?						umadin L				_
Do you was DENTURES? (Partials or Full)  Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)  PLEASE V TES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:  Would you like ko know more about PERMANENT REPLACEMENT?  Are you APPREHENSIVE about dental treatment?  Are you had any PERIODONTAL (GM) retainents?  Anaphylaxis	WHAT?				King:					
Are you UNHAPPY with your dentures?    PLEASE \( YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:   Would you like to know more about PERMANENT REPLACEMENT?   AlbS/HIV Pos.   Fainting   Psychiatric care   Park you have you had any PERIODONTAL (GUM) treatments?   Anaphylaxis   Food allergies   Rapid weight gain/loss   Park you the fainting   Psychiatric care   Park you had any PERIODONTAL (GUM) treatments?   Anaphylaxis   Food allergies   Rapid weight gain/loss   Park you the fainting   Psychiatric care   Park you had any PERIODONTAL (GUM) treatments?   Anaphylaxis   Food allergies   Rapid weight gain/loss   Park you the fainting   Psychiatric care   Park you have you had any PERIODONTAL (GUM) treatments?   Anaphylaxis   Food allergies   Rapid weight gain/loss   Park you the fainting   Psychiatric care   Park you have you had any PERIODONTAL (GUM) treatments?   Anaphylaxis   Food allergies   Rapid weight gain/loss   Park you will have you went to have you went the Appear of Griting in the you went to have HEADACHES, EARACHES, or NECK PAINS?   Back Problems   Heart purple   Shrothes of breath   Park you went ben't (PRTHODONTICS)?   Blood Disease   Heart purple   Herrophilia (Abnormal bleeding)   Skin rash   Park you went ben't (PRTHODONTICS)?   Blood Disease   Heart purple   Herrophilia (Abnormal bleeding)   Skin rash   Park you went ben't (PRTHODONTICS)?   Park you went ben't (PRTHODONTICS)?   Blood Disease   Heart purple   Herrophilia (Abnormal bleeding)   Skin rash   Park you went ben't (PRTHODONTICS)?   Park you went ben't (PRTHOD	7	-							-	
Would you like to know more about PERMANENT REPLACEMENT?         AIDS/HIV Pos.       Faintling		BOOLEN .	, , ,		-		OR PRES	SENTLY HAVE:		
Are you APPREHENSIVE about dental treatment?	Would you like to know more about PERMANENT REPLACEMENT?	NAME OF TAXABLE PARTY.		YES NO			YES NO			
Do your gums BLEED, or feel TENDER or IRRITATED?			Anaphylaxis		Food allergies			Rapid weight gain/loss		
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)										
Are you unter depth extended to the permitted						nlease describe				
Do you have HEADACHES, EARACHES, or NECK PAINS?			Asthma		, ,		2	Shortness of breath		
Have you worn BRACES on your teeth (ORTHODONTICS)?    Blood Disease						rmal bleeding)				
Do you have DISCOLORED teeth that bother you?    Cancer			<b>Blood Disease</b>		Hepatitis			Stroke		
Would you like your smile to LOOK BETTER or DIFFERENT?    Chemotherapy						ure			S	
Cortisone treatments			Chemotherapy		Kidney disease of	r malfunction		Thyroid disease or malfu		
Name of Previous Dentist?    Cough (persistent)	Do you REGULARLY use DENTAL FLOSS?									
Name of Previous Dentist?  Cough up blood Diabetes Diabet							LI LI			
City: State: Epilepsy	Name of Previous Dentist?		Cough up blood		Mitral valve prola	pse		Ulcer/Colitis		
ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?  Aspirin Local Anesthetic Erythromycin Latex (balloons, Nitrous Oxide Codeine Penicillin gloves, etc.)  Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.  FEAR of pain # LACK of concern # Is there any other Medical or Dental information that you feel we should know about?  COST of treatment # MISSING work time # FAMILY PHYSICIAN PHONE E-MAIL  To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I and/or my dependent(s), have insurance coverage with and assign directly to Dr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.										
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.  FEAR of pain # LACK of concern # Is there any other Medical or Dental information that you feel we should know about?  COST of treatment # MISSING work time # FAMILY PHYSICIAN PHONE E-MAIL  To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I and/or my dependent(s), have insurance coverage with and assign directly to Dr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.									ONS?	
Are you aware of being allergic to any other medications or substances?  If yes, list:  FEAR of pain # LACK of concern # Is there any other Medical or Dental information that you feel we should know about?  COST of treatment # MISSING work time # FAMILY PHYSICIAN * PHONE _ E-MAIL _ To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I and/or my dependent(s), have insurance coverage with _ and assign directly to Dr all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.			Nitrous Oxide	Codeine	Penicil	in				
FEAR of pain # LACK of concern # Is there any other Medical or Dental information that you feel we should know about?  COST of treatment # MISSING work time # FAMILY PHYSICIAN PHONE E-MAIL  To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I and/or my dependent(s), have insurance coverage with and assign directly to Dr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.				ng allergic to any other	er medications or s	ubstances?				
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	that I and/or my dependent(s), have insurance coverage with		and assign directly	to Dr.	all ins	urance benef	its, if any,	otherwise payable to me	ilth. I o	certify
	PATIENT Signature (Parent of Child)			Date:	DEN	TIST Signature	e			



Reston Dental Center / Tysons Dental Design Center /

www.restondentalcenter.com

# **New Patient Form**

# Financial Agreement

Reston Dental Center 12359 Sunrise Valley Drive, Suite 250 Reston, VA 20191 Tel: (703) 860-8613 Fax: (703) 860-8615

Tysons Dental Design Center 8150 Leesburg Pike Suite 830 Vienna, VA 22182 Tel: (703) 388-2883

Leesburg Dental Center 161 Fort Evans Rd, NE Suite 220 Leesburg, VA 20176 Tel: (703) 860-8613

Doctor Name: Jason K Hong, DMD

### Patient/Responsible Party Information

,,	
Name:	
Address:	
Social Security Number:	B.
I the undersigned hereby agree to pay to the above named doctor all fees due him incurred by me, my spouse or any of my children or dependents. <b>My co-paymen cable), is due at the time of treatment.</b> (initial) Acceptable forms of payr cards. There is also a payment plan called CareCredit, which allows you to start to time. Applying for CareCredit only takes a few minutes and there is no fee to apply	t, based on insurance benefits (if appliment are cash, check, and major credit reatment today and spread payments over
I understand the payment of my bill is my legal obligation as the patient. All filings eligibility of benefits and /or confirmation of insurance payments to be made by my Any assistance in this matter granted by the above doctor and/or staff is given strictly on their part for filing, follow-through or confirmations. If a balance remains or company processes my claim, the balance is due immediately. I understand between my insurance company and me. I also understand that I am responsaccount regardless of my insurance(initial)	vinsurance company are my responsibility.  ctly as a courtesy and implies no responsible  n my account after the insurance  that my insurance is an agreement
If my account is placed in the hands of an attorney for collection, I agree to pay att percent of the unpaid principal and interest that is or becomes due, plus all court one-half percent per month, beginning 30 days after the monies have become due stand and agree that the terms herein are reaffirmed each time services are received charges of \$35 per returned check.	costs, and interest in the amount of one and e or expenses have been incurred. I under-
Undersigned further agrees to pay a charge of \$25 per each half hour of rese cancellation/reschedule notice of at least 48 hours is not given.	erved appointment time when
	×
Patient/Responsible Party Signature	Date

www.restondentalcenter.com

## **New Patient Form**

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Reston Dental Center 12359 Sunrise Valley Drive, Suite 250 Reston, VA 20191 Tel: (703) 860-8613 Fax: (703) 860-8615 Tysons Dental Design Center 8150 Leesburg Pike Suite 830 Vienna, VA 22182 Tel: (703) 388-2883 Leesburg Dental Center 161 Fort Evans Rd, NE Suite 220 Leesburg, VA 20176 Tel: (703) 860-8613

Section A: Patient Information
Name: Address: Telephone: Social Security Number:
Section B: To the Patient Please Read the Following Statement Carefully
Purpose of consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations; i.e., you allow us to communicate with your insurance company, dental laboratories, if applicable to your treatment, as well as other specialty care dentists you may be referred to.
You have the right to read our Notice of Privacy Practices. The policy provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information.
We reserve the right to change our privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting Terri Novak at 703-860-8613.
SIGNATURE
I,, have had full opportunity to read and consider this Consent form. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
Signature: Date:
If this consent is signed by a personal representative on behalf of the patient (i.e., parent for minor child), complete the following:
Personal Representative's Name:
Relationship to Patient:

#### RIGHT TO REVOKE

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.