NOVA LifeSmiles
www.leesburgdentist.com info@leesburgdentist.com
17 C Fort Evans Rd NE | Leesburg, VA 20176 • Billing Questions Call, (703)777-5025

## Patient Information

**SSN *** _____

**Chart#:** _____
FOR OFFICE USE ONLY

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

**Birth Date:** _____ **Prev. Visit:** _____ **Email Address:** _____

**Phone:** _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

**Address:** _____ _____
Address 1 Address 2

_____ ___ _____-____
City State Zip Code

## Spouse or Responsible Party Information

**SNN** _____

**The following is for:** ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

**Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

**Birth Date:** _____ **Email Address:** _____

**Phone:** _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

**Address:** _____ _____
Address 1 Address 2

_____ ___ _____-____
City State Zip Code

**Date of last dental visit** _____

**Reason for this visit**

_____

_____

**Have you ever had any complications following dental treatment?** ◯ Yes ◯ No

**Have you ever had an unfavorable reaction to local anesthetic?** ◯ Yes ◯ No

**If yes, please explain**

_____

_____

**Have you ever had any periodontal (gum) treatment?** ◯ Yes ◯ No

**Are you dissatisfied with the appearance of your teeth?** ◯ Yes ◯ No

**If yes, What would you most like to change?**

_____

_____

**Why did you leave your last dental office?**

_____

_____

**Whom may we thank for referring you to our practice? ***

_____

_____

## Health Histoy

**Do you have any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ AIDS | ☐ Anemia | ☐ Arthritis | ☐ Artificial Joint | ☐ Asthma | ☐ Blood Disease |
| ☐ Cancer | ☐ Diabetes | ☐ Dizziness | ☐ Epilepsy | ☐ Excessive Bleeding | ☐ Fainting |
| ☐ Glaucoma | ☐ Growths | ☐ Hay Fever | ☐ Head Injuries | ☐ Heart Disease | ☐ Heart Murmur |
| ☐ Hepititis | ☐ High Blood Pressure | ☐ Jaundice | ☐ Kidney Disease | ☐ Liver Disease | ☐ Lupus |
| ☐ Lyme's Disease | ☐ Mental Disorders | ☐ Nervous Disorders | ☐ Pace Maker | ☐ PRE-MED | ☐ Radiation Treatment |
| ☐ Respiratory Problems | ☐ Rheumatism | ☐ Sinus Problems | ☐ Stomach Problems | ☐ Stroke | ☐ Tuberculosis |
| ☐ Tumors | ☐ Ulcers | ☐ Venreal Disease | ☐ Other | ☐ Pregnant | |

**Do you have any of the following allergies:**

☐ Environmental ☐ Food ☐ Nuts ☐ Seasonal ☐ Codeine ☐ Epinephrine ☐ Motrin ☐ Penicillin
☐ Sulfa Drugs ☐ Tetracycline ☐ Latex

**List all medications you are currently taking:**

_____

_____

_____

_____

_____

**Are you under the care of a physician?** ◯ Yes ◯ No

**Do you have any health problems that need further clarification?** ◯ Yes ◯ No

**Have you been admitted to a hospital or needed emergency care within the past two years?** ◯ Yes ◯ No

## Employment Information

**The following is for:** ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

**Employer Name:** _____ **Phone:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

## Primary Insurance Information

**Primary Dental Insurance:**

**Name of Insured:** _____ _____ ____
Last First MI

**Insured's Birth Date:** _____ **ID #:** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Insured's Employer Name:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Patient's relationship to insured:** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:** _____

**Insurance Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

## Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian (responsible party):

Signature _____ **Date** _____

**Relationship to Patient:**

_____

_____

**Please provide us with the name and phone number of your previous dentist so that we may request your dental records.**

_____

_____

☐ **I give my permission for Dr Kokels office to request my dental records to be forwarded to drkokel@leesburgdentist.com**

## NOVA LifeSmiles
## Financial Agreement

Payments:
I understand that all copayments are due at the time of service.
I understand that if I have an outstanding balance, it must be paid before seeing the doctor for new treatment unless other arrangements have been made with the billing department prior to the appointment. I understand that all cosmetic procedures not covered by insurance must be paid in full at the time services are rendered. I understand that it is my responsibility to inquire about final costs before I choose to have any procedures performed. I understand that I am responsible for 100% of my bill if insurance isn't remitted in 60 days. If my account becomes assigned to a collection agency, I agree to pay the agencies collection fee, interest in the amount of 18%, court costs, and attorney fees, as allowed by law. I understand that payment options in the office include cash, check, debit card, MasterCard, Visa, Discover, American Express and Care Credit. I understand there is a $50 fee for any returned checks to the office.

NOTICE OF NON-COVERED SERVICES:
The dentist may recommend a procedure that is not a covered benefit with your insurance carrier. Insurance carriers will only pay for services that are covered by your particular plan. Some services, such as fluoride or cosmetic dentistry may not be a covered benefit; however, the doctor will not base your plan of care on insurance coverage. All non-covered services must be paid in full at the time of service. In cases where your insurance company denies payment for services rendered, you are responsible for payment of your treatment. All retail products must be paid for at the time of purchase.

HIPAA Policy
I have been given a copy of NOVA LifeSmiles PLLC's HIPAA policy to read. Copies are available upon request.

Cancellation Policy
I understand that even though the office may call/text or email to confirm appointments, it is ultimately my responsibility to remember my appointment.
I understand that if I fail to cancel/reschedule my appointment at least 48 hours in advance, I will be charged a minimum $50 failed appointment fee. . I understand that I must call the office to cancel any appointment.

Insurance
I understand that NOVA LifeSmiles PLLC's files all insurances as a courtesy. The practice will give the patient, when requested, an estimate of out of pocket expense.

Your agreement with the insurance company is between you and your insurance company. Any assistance by the doctor and/or staff in filing of insurance papers or confirmation of insurance payments is strictly given as a courtesy and implies no responsibility on their part for follow up confirmation. If the insurance company does not remit payment within 60 days after the date of service, we will bill you with the remaining balance due and payable upon receipt from you.
Patient Consent
I understand that providing proof of my insurance does not hold NOVA LifeSmiles PLLC responsible for verifying this information. I accept financial responsibility in understanding my insurance benefits at the time services are rendered. I understand that is my responsibility to notify the office of any changes to my insurance information (new prefix to ID#, new group #, claim submission address, etc.), or personal address or phone information.

I will cooperate with the billing department of NOVA LifeSmiles PLLC to ensure payment for my services. I understand that I will be responsible for any costs associated with the collections of my account if I default on this agreement. I understand the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent/legal guardian of said patient and agree that I am responsible for all payments for all services rendered to the patient herein.

I have read and agree to comply with NOVA LifeSmiles PLLC's financial agreement.

Patient's Name_____

Date_____

Signature_____

Patients Name_____

## ACKNOWLEDGEMENT OF RECEIPT
## OF
## NOTICE OF PRIVACY PRACTICES

I will request and read a copy of NOVA LifeSmiles PLLC Notice of Privacy Practices upon arrival to the office.

Please print your name

Signature

Date

Authorization to Release Information to Family Members
Many of our patients allow family members such as their spouse, parent, or others to call and request the results of tests and procedures. Under the requirements for H.I.P.A.A., we are not allowed to give this information to anyone without the patients consent. If you wish to have your information released to family members you must authorize and sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. This consent form will not allow Deidra B Kokel DDS, PC to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

1. Name_____Relationship to Patient _____Date_____

2. Name_____Relationship to Patient _____Date_____

Authorization to Leave Message with Household Members/Answering Machine
From time to time it is necessary for representatives of NOVA LifeSmiles PLLC to leave a message for patients. The purpose of these messages is to remind patients that they have an appointment, notify the patient that the staff would like to discuss lab or procedure results or to ask a patient to call the office regarding an issue or concern. At no time will a representative of NOVA LifeSmiles PLLC discuss your medical circumstances without your consent. The purpose of this consent is to leave a message with members of your household or on your answering machine.

You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

_____

## Photo and Video Usage Authorization

I _____, hereby authorize NOVA LifeSmiles PLLC or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face . I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, contest, etc). I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs or videos. If I wish to revoke this consent, I may do so in writing. If declining this consent, leave blank. Please initial one option:
_____I do not mind if my photographs/video are used in any of the above stated situations.
_____I only agree to have my teeth shown without any identifying features.

Patient Name:_____

Signature:_____Date_____

## Consent for Treatment of a Minor/Dependent Child

I, _____, parent of

_____, give permission to associate doctors and clinical staff members employed by NOVA LifeSmiles PLLC to treat the above stated child(ren) in my absence for dental care. I agree that all financial responsibility will be paid by myself and that I will call the office with payment prior to my child(ren)'s appointment(s) or an acceptable payment method will be sent with my child(ren) to the appointment(s). I acknowledge that I have been made aware of the estimated patient responsibility for said care and that I may request a preauthorization prior to treatment. I also acknowledge that there is a 48 hour cancellation policy and that any missed appointments by my child(ren) will result in a $50 cancellation fee per incident.

Print Name

_____ _____

Signature Date

## Authorization for Use of Credit Card Upon Treatment of Minor/Dependent Child

I, _____,
authorize NOVA LifeSmiles PLLC or agents, to charge my credit card for all fees related to my child(ren)'s care. If I opt out of providing credit card information, I

understand that payment is expected at the time of service and I agree to provide my unaccompanied child(ren) with an acceptable payment method.
Credit card number _____

Expiration date _____ Security code _____ Billing zip code _____

_____

Print Name

_____

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**Response Date:** ____/____/_____