PATIENT NAME _____, _____, _____
LAST **FIRST** **M.I.**

WELCOME & THANK YOU FOR CHOOSING

DENTAL GROUP OF TYSONS

Today's Date _____

PATIENT INFORMATION

If you have any questions or concerns, do not hesitate to ask for assistance. PLEASE PRINT THE INFORMATION REQUESTED. THANK YOU.

NAME _____, _____, _____
LAST FIRST M.I.
DATE OF BIRTH _____ SS# _____

ADDRESS _____, _____, _____, _____
CITY STATE ZIP

HOME PHONE (___) _____ CELL PHONE (___) _____ WORK PHONE (___) _____

EMAIL ADDRESS: _____ SEX: MALE_____FEMALE_____MARITAL STATUS_____

PATIENT EMPLOYER/SCHOOL: _____ OCCUPATION: _____

SPOUSE OR PARENT'S NAME: _____ EMPLOYER: _____

SPOUSE OR PARENT'S WORK PHONE (____) _____

WHOM MAY WE THANK FOR YOU REFERRING YOU TO US? _____

CONTACT IN CASE OF EMERGENCY_____PHONE (____) _____

RESPONSIBLE PARTY:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____

RELATIONSHIP TO PATIENT _____ PHONE (____) _____

ADDRESS _____, _____, _____, _____
CITY STATE ZIP

NAME OF EMPLOYER _____ WORK PHONE (____) _____

PATIENT NAME _____, _____, _____
LAST **FIRST** **M.I.**

PATIENT MEDICAL HISTORY (PLEASE FILL OUT COMPLETELY) PLEASE CIRCLE

ARE YOU UNDER MEDICAL TREATMENT NOW?..... YES NO
OR WITHIN THE PAST YEAR?..... YES NO

ARE YOU TAKING ANY DRUGS OR MEDICATIONS?..... YES NO
OR WITHIN THE PAST YEAR?..... YES NO
IF YES, WHAT? _____

HAVE YOU EVER HAD ANY MAJOR OPERATION?..... YES NO

HAVE YOU EVER HAD ANY COMPLICATIONS DURING OR AFTER AN OPERATION?
ANESTHETIC, OR TOOTH EXTRACTION?..... YES NO

(WOMEN ONLY) ARE YOU PREGNANT AT THIS TIME OR THINK YOU MIGHT BE?..... YES NO

ARE YOU WEARING CONTACT LENSES?..... YES NO

ARE YOU ALLERGIC TO OR HAVE HAD ANY REACTIONS TO THE FOLLOWING?..... YES NO
PENICILLIN OR ANY ANTIBIOTICS..... YES NO
CODEINE..... YES NO
LOCAL ANESTHETIC (E.G. NOVACAINE) ..... YES NO
OTHER (PLEASE LIST) ..... YES NO
_____
DO YOU HAVE A COUGH OR A COLD?..... YES NO
DID SOMEONE COME WITH YOU TO DRIVE YOU HOME?..... YES NO
HAVE YOU HAD ANYTHING TO EAT OR DRINK WITH THE LAST SIX HOURS?..... YES NO
DO YOU HAVE OR HAVE YOU AHD ANY OF THE FOLLOWING? (PLEASE CIRCLE)

HEART DISEASE	EPILEPSY	ASTHMA	STOMACH PROBLEM
BLOOD DISORDER	ARTHRITIS	ANEMIA	VENEREAL DISEASE
LIVER PROBLEM	AIDS	SINUYS TROUBLE	EMPHYSEMA
STROKE	KIDNEY DISEASE	HEPATITIS	LUNG PROBLEM
GLAUCOMA	CANCER	CIRRHOSIS	HIGH BLOOD PRESSURE
RHEUMATIC FEVER	TUBERCULOSIS	DIABETES	PSYCHIATRIC TREATMENT
IMMUNE DISORDER	YELLOW JAUNDICE	HEART MURMUR	LIVER TROUBLE
BREATHING PROBLEM	HIV POSITIVE	LEUKEMIA	PROLONGED BLEEDING

HAVE YOU HAD ANY OTHER SERIOUS ILLNESS?..... YES NO
IF YES, WHAT?
_____

I CERTIFY THAT I HAVE READ AND UNDERTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INOCRRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AGREE TO BE RESPONSIBLEJ FOR THE PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____
SIGNATURE OF PATIENT (OR PARENT/LEGAL GUARDIAN, IF MINOR) **DATE**

 INITIALS _____ TODAY'S DATE_____

PATIENT NAME _____, _____, _____
LAST **FIRST** **M.I.**

TELL US ABOUT YOUR SMILE ☺

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 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 EXISITNG CROWNS OR DENTAL WORK YOU CONSIDER “UGLY”?	YES	NO
ARE YOU SELF-CONCIOUS OF YOUR TEETH AND/OR SMILE?	YES	NO
DO YOU AVOID SMILING WHEN YOU HAVE YOUR PICTURE TAKEN?	YES	NO
DO YOU WISH YOU HAD A “NEW SMILE”?	YES	NO

IS THERE ANYTHING ELSE REGARDING YOUR SMILE THAT YOU WOULD LIKE FOR US TO TALK TO YOU ABOUT?

_____
_____
_____
_____
_____

PATIENT NAME _____, _____, _____
LAST **FIRST** **M.I.**

We are very pleased that you have chosen our office for your dental care.
Dr. Esam Abou Nahlah is proud to have the opportunity to provide you with gentle, efficient and state of the art dental services. We hope to make your visits with our practice as pleasant and comfortable as possible. Please take a moment to familiarize yourself with our office policies and procedures. Please let us know if you have any questions or concerns.

OFFICE POLICY

-Our fees are meant to be fair and reasonable. We strive to keep them that way. You assist that effort when pay for our services at the end of each visit.

-Our staff can explain the approximate estimated fee for treatment prior to the next appointment. To make payments as convenient for you, we honor cash, checks, VISA, MASTERCARD, Discover or AMEX. We also have monthly payment plans, through multiple financial organizations. Please ask our team for more details.

-If you have questions regarding your insurance coverage or co-payment please let us answer your questions before any treatment starts. Otherwise, we will assume that you are familiar with your dental plan coverage and limitations.

-Payment and or co-payment and deductibles are required in full at the time of service. Any difference will be credited or billed after the insurance payment has been received. Please be advised that any co-payment amount is just estimated based on the information given by the insurance company at the time a plan is verified. The information given over the phone is not a guarantee of payment by the insurance company, and actual payment may differ. **Any insurance payment not received after 60 days, you, the patient will be ultimately responsible for the full amount.**

-There will be a $25.00 charge for all returned checks. Payment in the form of cash or money order is expected within 10 days of notification.

-If an outstanding account has not been paid in 90 days, a monthly service charge will be added. If the account is not cleared, our office will turn the account to our attorney for collection. If this account is placed in the hands of any attorney for collection, the undersigned agrees to pay an amount equal to one-third of the unpaid principal and interest as a collection fee, plus court cost and interest in the amount of 2 percent per month, beginning 60 days after the monies have become due and expenses have been incurred.

-We require at least 48 hours' notice for all appointment cancellations or rescheduling. $50.00 per ½ hour of appointment will be charged for each broken appointment.

-If you have any questions about your dental coverage, your account and/or our office policies, please do not hesitate to ask.

I have read and understand the above policies and agree to be held financially responsible for accounting matters.

_____

SIGNATURE OF PATIENT (OR PARENT/LEGAL GUARDIAN, IF MINOR) **DATE**

 INITIALS _____ TODAY'S DATE_____

PATIENT NAME _____, _____, _____
LAST **FIRST** **M.I.**

INSURANCE INFORMATION (MEDICAL WITH LIMITED DENTAL)

NAME OF INSURED _____, _____, _____
LAST FIRST M.I.

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH _____ SS/ID# _____

NAME OF EMPLOYER _____ WORK PHONE (____) _____

ADDRESS _____, _____, _____, _____
CITY STATE ZIP

INSURANCE COMPANY _____ GROUP # _____

ISURANCE COMPANY ADDRESS _____, _____, _____, _____
CITY STATE ZIP

INSURANCE INFORMATION (DENTAL PRIMARY)

NAME OF INSURED _____, _____, _____
LAST FIRST M.I.

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH _____ SS/ID# _____

NAME OF EMPLOYER _____ WORK PHONE (____) _____

ADDRESS _____, _____, _____, _____
CITY STATE ZIP

INSURANCE COMPANY _____ GROUP # _____

ISURANCE COMPANY ADDRESS _____, _____, _____, _____
CITY STATE ZIP

INSURANCE INFORMATION (DENTAL SECONDARY)

NAME OF INSURED _____, _____, _____
LAST FIRST M.I.

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH _____ SS/ID# _____

NAME OF EMPLOYER _____ WORK PHONE (____) _____

ADDRESS _____, _____, _____, _____
CITY STATE ZIP

INSURANCE COMPANY _____ GROUP # _____

ISURANCE COMPANY ADDRESS _____, _____, _____, _____
CITY STATE ZIP

PATIENT NAME _____, _____, _____
LAST **FIRST** **M.I.**

NOTICE OF PRIVACY PRACTICES

DENTAL GROUP OF TYSONS
Dr. Esam Abou Nahlah

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on April 14, 2004 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.
HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
PERSONS INVOLVED IN CARE: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

PATIENT NAME _____, _____, _____
LAST **FIRST** **M.I.**

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.
REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.
ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.
APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with an appointment reminder, such as voicemail messages, email messages, postcards or letters.

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.00 for first copy; additional copies can be provided if requested in writing for a standard fee of $20.00 plus applicable postage fees. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.
DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to additional requests.
RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.
ELECTRONIC NOTICE: If you receive this Notice on our Website or by electronic mail (e-mail) you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our private practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision w made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us in writing using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address for the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Dept. of Health and Human Services.

CONTACT OFFICER: **Esam Abou Nahlah, DDS, M.S.**
ADDRESS: **7901 Jones Branch Dr., Ste. 220, McLean, VA 22102**
PHONE: **703-448-3312**
FAX: **703-448-3938**
EMAIL: **INFO@TYSONSDENTAL.COM**

PATIENT NAME _____, _____, _____
LAST **FIRST** **M.I.**

ACKNOWLEDGEMENT OF NOTICE
OF OFFICE POLICY REGARDING PRIVACY PRACTICES

I have been given the opportunity to review and ask questions regarding the **Notice of Privacy Practices** for the Dental Group of Tysons. A copy of this policy has been offered to me.

_____

Please print name

_____

Signature and Date

_____

For office use only

Copy requested and given to patient by _____ date_____
Team member

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency prevented us from obtaining acknowledgement

Other: (please specify)

_____

_____

_____