# Dumfries Dental Arts

17775 Main Street, Suite 103, Dumfries, VA 22026
(703) 445-9022

## New Patient Registration

Please fill out this form as completely as you can. If you have questions, we're happy to help — just call us at (703) 445-9022.

## Patient Information

Last Name | First Name | Initial

Address | Soc. Sec. # (optional)

City | State | Zip | Home Phone

Cell Phone | Email

Sex ☐ M ☐ F

Age | Birthdate

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by | Occupation

Business Address | Business Phone

Business Email

Whom may we thank for referring you?

Notify in Case of Emergency | Home Phone

Cell Phone | Business Phone

Email

## Primary Insurance

Last Name | First Name | Initial

Person responsible for account

Relation to Patient | Birthdate | Soc. Sec. #

Address (if different from patient) | Home Phone

City

State

Zip

Email

Person Responsible Employed by

Occupation

Business Address

Business Phone

Business Email

Insurance Company

Phone

Insurance Address

Contract #

Group #

Subscriber #

Name of Other Dependents Under This Plan

Pharmacy Name

Phone

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## Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name | Relation to Patient | Birthdate

Address (if different from patient) | Soc. Sec. #

City | State | Zip | Home Phone

Cell Phone | Email

Subscriber Employed by | Business Phone

Business Email | Phone

Insurance Company

Insurance Address | Phone

Contract # | Group # | Subscriber #

Name of Other Dependents Under This Plan

## Dental History

What would you like us to do today?

Are You in Dental Discomfort Today?

Former Dentist | Address

Dentist's Email | Phone

Date of Last Dental Care | Date of Last X-Rays

**Check yes or no if you have had problems with any of the following:**

| | | | |
|---|---|---|---|
| ☐ Y ☐ N | Bad breath | ☐ Y ☐ N | Periodontal treatment |
| ☐ Y ☐ N | Bleeding gums | ☐ Y ☐ N | Sensitivity to cold |
| ☐ Y ☐ N | Clicking or popping jaw | ☐ Y ☐ N | Sensitivity to hot |
| ☐ Y ☐ N | Food collection between teeth | ☐ Y ☐ N | Sensitivity to sweets |
| ☐ Y ☐ N | Grinding or clenching teeth | ☐ Y ☐ N | Sensitivity when biting |
| ☐ Y ☐ N | Loose teeth or broken fillings | ☐ Y ☐ N | Sores or growths in mouth |

How Often Do You Brush?

Floss?

How Do You Feel About the Appearance of Your Teeth?

Do you wish your teeth were straighter? ☐ Yes ☐ No

Do you wish your teeth were whiter? ☐ Yes ☐ No

Are you unhappy with any fillings, crowns, bridges? ☐ Yes ☐ No

Ever had an adverse reaction to a medical/dental procedure? ☐ Yes ☐ No

Are you currently under physician care? ☐ Yes ☐ No

Other information about your dental health or previous treatment

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## Medical History

Physician's Name

Phone

Date of Last Visit

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe

Are you currently under physician care? ☐ Yes ☐ No

If yes, describe

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, give approximate dates

Have you ever taken Fen-Phen / Redux? ☐ Yes ☐ No

Ever used a bisphosphonate medication? (Fosamax, Actonel, etc.) ☐ Yes ☐ No

Do you smoke or use other tobacco/smokeless products? ☐ Yes ☐ No

If so, which: ☐ Cigarettes ☐ Cigars ☐ Vape ☐ Marijuana ☐ Chew

Other

**For women:**

Are you pregnant? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

**Check yes or no whether you have had any of the following:**

| | | |
|---|---|---|
| ☐ Y ☐ N AIDS/HIV Positive | ☐ Y ☐ N Epilepsy | ☐ Y ☐ N Psychiatric care |
| ☐ Y ☐ N Anaphylaxis | ☐ Y ☐ N Fainting | ☐ Y ☐ N Rapid weight gain or loss |
| ☐ Y ☐ N Anemia | ☐ Y ☐ N Food allergies | ☐ Y ☐ N Radiation treatment |
| ☐ Y ☐ N Arthritis, Rheumatism | ☐ Y ☐ N Glaucoma | ☐ Y ☐ N Respiratory disease |
| ☐ Y ☐ N Artificial heart valves | ☐ Y ☐ N Headaches | ☐ Y ☐ N Rheumatic / Scarlet fever |
| ☐ Y ☐ N Artificial joints | ☐ Y ☐ N Heart murmur | ☐ Y ☐ N Shingles |
| ☐ Y ☐ N Asthma | ☐ Y ☐ N Heart problems | ☐ Y ☐ N Shortness of breath |
| ☐ Y ☐ N Atopic (allergy prone) | ☐ Y ☐ N Hemophilia / Abnormal bleeding | ☐ Y ☐ N Skin rash |
| ☐ Y ☐ N Back problems | ☐ Y ☐ N Herpes | ☐ Y ☐ N Spina Bifida |
| ☐ Y ☐ N Blood disease | ☐ Y ☐ N Hepatitis | ☐ Y ☐ N Stroke |
| ☐ Y ☐ N Cancer | ☐ Y ☐ N High blood pressure | ☐ Y ☐ N Surgical implant |
| ☐ Y ☐ N Chemical dependency | ☐ Y ☐ N Jaw pain | ☐ Y ☐ N Swelling of feet or ankles |
| ☐ Y ☐ N Chemotherapy | ☐ Y ☐ N Kidney disease or malfunction | ☐ Y ☐ N Thyroid disease or malfunction |
| ☐ Y ☐ N Circulatory problems | ☐ Y ☐ N Liver disease | ☐ Y ☐ N Tobacco habit |
| ☐ Y ☐ N Cortisone treatments | ☐ Y ☐ N Material allergies (latex, wool, metal) | ☐ Y ☐ N Tonsillitis |
| ☐ Y ☐ N Cough, persistent | ☐ Y ☐ N Mitral valve prolapse | ☐ Y ☐ N Tuberculosis |
| ☐ Y ☐ N Cough up blood | ☐ Y ☐ N Nervous problems | ☐ Y ☐ N Ulcer / Colitis |
| ☐ Y ☐ N Diabetes | ☐ Y ☐ N Pacemaker / Heart surgery | ☐ Y ☐ N Venereal disease |

Are you currently taking any medications? If yes, list all

Do you have any drug allergies? If yes, list all

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## Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance.

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

Signature

Date

## Patient HIPAA Consent Form

I understand that as part of my healthcare, this office originates and maintains health records describing my history, symptoms, examinations, test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that this office has the right to change its notice and practices, and prior to implementation will mail a copy of any revised notices to the address I have provided. I understand I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payments, and healthcare operations, and that this office is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the office has already acted in reliance thereon.

Print Patient Name

Signature

Date

Relationship to Patient

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## Financial & Appointment Agreement

### Treatment of Minors

Care for a patient under 18 years of age must be authorized by a parent, legal guardian, or someone to whom you give written consent to present the child for care.

### Insurance Patients

If you have dental insurance, we will file insurance claims on your behalf as a courtesy to our patients. Remember that your insurance contract is between you and your insurer. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance. It is also our policy that all estimated deductibles and co-insurance (the amount owed after insurance pays its portion) be paid at the time of service. This is an estimated amount. If your insurance company has not paid your claim within 60 days, the balance of your claim will be transferred to you.

### X-Rays

If you have current x-rays from a previous dentist, it is your responsibility to bring those to your appointment or to arrange for their transfer. If you do not notify us that you have current films/digital x-rays, we will take new ones. Insurance companies have limitations on how often they will pay for x-rays.

### Patient Responsibility of Balances

You will be responsible for: services not covered by insurance, co-pays, deductibles, and balances remaining after your insurance company has paid. Payment in full is expected within 30 days from your first statement advising you of the balance due. For your convenience, we accept cash, personal check, Visa, MasterCard, Discover, and American Express as forms of payment. If a check is returned to us for any reason, a $35.00 fee will be charged.

### Missed Appointments

We understand that emergency situations do arise that may require you to change an appointment. As a courtesy to other patients and our office, we ask for 48 hour notice of any change to your appointment. If any appointment is failed, or repeatedly changed, a fee will be charged and/or you may be asked to find a new dentist.

### Acknowledgement and Authorization

I have read, understand, and agree to the above policies. I authorize the release of medical information necessary to process a claim for benefits under my policy and assign payment of my insurance benefits to Dumfries Dental Arts.

Signature

Date