PATIENT ACQUAINTANCE FORM

Date: ___/___/___

Patient's Name: _____ M___ F___ *Birthdate:* ___/___/___
Address: _____ *SSN:* ___-___-___
_____ *Home Ph.:* (___) ___-_____
_____ *Work Ph.:* (___) ___-_____

Person Responsible for Account:
*Name*_____ *Home Ph.:* (___) ___-_____
Address: _____ *Work Ph.:* (___) ___-_____
_____ *SSN:* ___-___-___

Place of Employment: _____ *Occupation:* _____

Who can we thank for referring you to our office? _____

****

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing below, I give my consent to use or disclose my protected health information to carry out treatment, payment activities and healthcare operations.

Your consent permits us to do the following: (Keep in mind that none of these are new practices.)

- Communicate between staff members for your optimal care
- Contact a referral doctor or laboratory on your behalf
- Phone in a prescription to your pharmacy
- Call your home, cell or work number
- Mail or email and/or text reminder cards, bills and correspondence to your home or alternate address
- Have prosthetic prescriptions completed by our labs
- Submit claims to insurance
- Other healthcare, treatment and/or payment-related functions

You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our Notice 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 matter about your protected health information. You may have a copy of this Notice upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we do so, we will issue a revised notice containing the changes.

You have the right to restrict or revoke this consent upon written notification, however the office is not obligated to agree to the restriction, and the restriction/revocation will not be effective prior to the date of receipt of notice.

Signed: _____ Date: _____

For Office Use only:
We attempted to obtain written consent but could not because:
___ Individual refused to sign ___Communication barrier prohibited consent
___ An emergency situation prevented consent ___Other _____

Employee Name: _____Date: _____

Signature: _____

FINANCIAL INFORMATION

We are committed to providing you with the best possible dental care. In order to begin a long lasting, professional relationship, we ask for your understanding of and cooperation with our payment policy.

In-Network Plan Patients:
As a contracted provider for these plans, we will submit your claims and receive the corresponding payments. You will be responsible for making any estimated co-payments at the time of service and paying any residual balance.
Out-of-Network Plan Patients: *We will submit all claims and collect an estimated copayment for your service provided we have been able to confirm eligibility.*
Any remaining balance after insurance payment has been received will be due upon receipt of statement for all patients.

Financial alternatives for extensive treatment can be discussed with our front staff and approved by the office manager. Financial arrangements are per occasion and are not to be considered permanent arrangements.

OTHER IMPORTANT ITEMS:

1) *When appropriate, we will be happy to submit a pre-treatment estimate to your insurance company at your request and after you have provided appropriate insurance information.*
2) *Interest, at the rate of 1.5% per month, will be applied to all balances exceeding 90 days.*
3) *Accounts exceeding 60 days since last payment will be reviewed for collection by a third party.* ***If you receive a statement you do not understand, please call us immediately. DO NOT IGNORE the statement.*** *Communication is key to our relationship.*
4) *If an account requires collection by a third party, the patient/guarantor will be responsible for all collections fees (50% of original balance + $25), attorney's fees, court fees, and any/all other costs incurred to collect your debt. We sincerely hope these measures will never become necessary.*
5) ***A minimum $50.00 fee will be charged to your account for broken appointments and appointments canceled without 24 business hours prior notice.*** *We appreciate your respect for other patients who can utilize your reserved time and your respect for our time. We will extend the same courtesy.*

6)Prosthetic cases (crown, bridge, veneers, etc.) and cosmetic bleaching will require a down payment when started and will not be delivered until final payment has been received or specific financial arrangements are on file, including a valid credit card number.
7)A credit report may be requested prior to approving in-office payment plans.
8) Military only: I authorize you to talk to my/my spouse's superiors if I am delinquent in paying my account.
9)There will be a charge of $25.00 for all returned checks. Checks which are not rectified immediately will be surrendered to a third-party collector for legal action.
10) A ***Deposit will be required in some instances****, such as periodontal procedures and lengthy restorative appointments. This deposit will apply to your estimated copay unless the appointment is broken or cancelled within 48 hours. It will then be applied as a broken appointment fee and will be non-refundable.*

If you have any questions concerning the above information, please do not hesitate to ask. We are here to help you!

I have read and understand the above information

_____

Patient, Parent or Guardian

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐
Weight: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Problems
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Sleep Apnea

Y	N	Conditions
☐	☐	Snoring
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

DENTAL HISTORY

Name: _____ *Date:* _____

What is the main reason for your visit today? _____
Date of Last Physical Examination: _____
Date of Last Dental Examination: _____ *Dentist's Name:* _____
Date of Last Dental X-rays: _____

Circle		
Yes	*No*	*Are you having pain or discomfort at this time?* _____
Yes	*No*	*Do you feel very nervous about having dental treatment?* _____
Yes	*No*	*Have you ever had a bad experience in the dental office?* _____
Yes	*No*	*Is there anything that you dislike about your smile?* _____
Yes	*No*	*Have you been a patient in the hospital during the past two years?* _____
Yes	*No*	*Have you been under the care of a medical doctor during the past two years?* _____
Yes	*No*	*Are you taking any vitamins or herbal supplements?* _____
Yes	*No*	*Have you ever had any excessive bleeding requiring special treatment?* _____
Yes	*No*	*Have you ever taken prescription Redux or Pondimin (Fen Phen)?* _____
Yes	*No*	*Are there now any growths or sores in or around your mouth?* _____
Yes	*No*	*Do you have any trouble chewing?* _____
Yes	*No*	*Does food catch between your teeth?* _____
Yes	*No*	*Do you have pain in or near your ears?* _____
Yes	*No*	*Do you habitually clench or grind your teeth during the day or night?* _____
Yes	*No*	*Have you experienced clicking or popping of your jaw?* _____
Yes	*No*	*Have you ever been told that you have gum problems?* _____
Yes	*No*	*Do you now have bleeding gums or any other gum condition?* _____
Yes	*No*	*Do you or your spouse snore?* _____
Yes	*No*	*Have you ever been told you have or may have sleep apnea?* _____
Yes	*No*	*Is there anything related to your medical or dental history that you have not indicated Above? If yes, please explain:* _____

Home

About Us

Services

Technology

Forms

Contact Us/Directions

Insurance Participation

Military Families

PRIVACY POLICY

This privacy notice applies solely to information collected by this web site. It will notify you of the following:

1. What personally identifiable information is collected from you through the web site, how it is used and with whom it may be shared.
2. What choices are available to you regarding the use of your data.
3. The security procedures in place to protect the misuse of your information.
4. How you can correct any inaccuracies in the information.

Information Collection, Use, and Sharing

How this information is transferred to a third party: We are the sole owners of the information collected on this site. We only have access to/collect information that you voluntarily give us via email or other direct contact from you. We will not sell or rent this information to anyone.

How is this information used by the company: We will use your information to respond to you, regarding the reason you contacted us. We will not share your information with any third party outside of our organization, other than as necessary to fulfill your request, e.g. to process your claim, or to facilitate payment.

Unless you ask us not to, we may contact you via email in the future to tell you about specials, new products or services, or changes to this privacy policy.

Your Access to and Control Over Information

Opt out statement& modify/delete statement: You may opt out of any future contacts from us at any time. You can do the following at any time by contacting us via the email address or phone number given on our website:

- See what data we have about you, if any.
- Change/correct any data we have about you.
- Have us delete any data we have about you.
- Express any concern you have about our use of your data.

If you feel that we are not abiding by this privacy policy, you should contact us immediately via telephone or you can e-mail us through our website's home page.

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