Riding Plaza Dental Care

25055 Riding Plaza, Suite 210
South Riding, VA 20152
Tel: (703) 327-9935 Fax: (703) 327-9976

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Sex (M/F): _____ Marital Status: _____ Birth Date: _____

Social Security #: _____ E-mail Address: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ **Reason for today's visit**: _____

Are you interested in whiter teeth? ☐ Yes ☐ No

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergy Codeine
- ☐ Allergy Penicillin
- ☐ Allergy Latex
- ☐ Allergy Metals
- ☐ Allergy Rubber
- ☐ Allergy Other

_____

_____

_____

- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Transfusions
- ☐ Breathing Difficulties
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic Cough
- ☐ Chemotherapy
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Coronary artery Disease
- ☐ Diabetes
- ☐ Dizziness
- ☐ Earaches/ringing in ears
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fever Blister/Cold Sores
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headache/Migraine
- ☐ Head Injuries
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart & Valve defects
- ☐ Hepatitis
  - ☐ A
  - ☐ B
  - ☐ C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Care
- ☐ Nervous Disorders
- ☐ Oral Cancer/Tumor
- ☐ Pacemaker
- ☐ Prosthetic Joint(s)
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
  - ☐ Hypo
  - ☐ Hyper
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

OTHER:
☐ _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No Date of last complete exam? _____
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any medications at this time? ☐ Yes ☐ No

Medication	**Dosage**	**How Often**	**How Long**	**Reason**

For additional medications please continue on the back of this page →

Patient Name: _____ **Date:** _____

Do you use tobacco in any form? ☐ Yes ☐ No
If yes, how much? _____ How Long? _____

• Have you ever had any serious trouble associated with dental treatment/surgery/extraction? ☐ Yes ☐ No
If yes please explain? _____

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

• Have you ever had an unusual reaction to dental anesthetics? ☐ Yes ☐ No
If yes, please explain _____

In case of emergency, who should we contact: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If a change in my health status occurs, I will inform the dentist at the next appointment.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Riding Plaza Dental Care Patient
☐ Dental Office ☐ Yellow Pages ☐ Southridingonline.com ☐ Clipper Magazine ☐ Other _____

Name of person or office referring you to our practice: _____

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Patient Name: _____ **Date:** _____

Consent for Dental Services and Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from patients for the costs incurred in their care and 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 at the time services are performed.

This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such 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.

Late payment terms: 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. There will also be a late fee of $25.00 per month applied to your balance for every month or portion of a month you have not paid after 60 days. All returned checks will incur a $35.00 processing fee.
Refund Policy: Once services are performed, there are no refunds.
Record Transfer Fees: There will be an administrative fee for transferring any dental radiographs or images to other offices as well as personal e-mails.

Broken Appointments: We reserve appointment times especially for you. Our goal is to give every patient a courtesy reminder call in advance of a scheduled visit. However, you are expected to keep your appointment even without a courtesy call from us. We ask that you give us at least 24 hours notice of a cancelled appointment. A broken appointment is a loss to you, your dentist, and her staff and to another patient who could have had your appointment time. Accordingly, if 24 hours notice is not given, we have the right to charge you a minimum of $50.00 as a broken appointment fee.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered. If my account is placed in the hands of an attorney or collection agency for collection, I further agree to pay all costs and 33.3% attorney's fees, collection agency fees, court filing fees, and processing fees if a lawsuit is instituted hereunder, which will include but is not limited to an additional $150.00 processing fee and any legal or administrative costs as a result of my failure to pay for the professional services rendered.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I HAVE READ THIS POLICY CAREFULLY AND FULLY UNDERSTAND AND AGREE TO ALL ITS TERMS.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Insurance Consent and Financial Terms

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. We accept assignment of estimated insurance benefits as a courtesy to our patients. Please note that your dental insurance is a contract between you and the insurance company. If insurance does not cover your treatment, in whole or part, or is cancelled or terminated for any reason, or cannot be verified, you will be responsible for the entire fee. As a courtesy to you, we use available information to estimate for you how much your insurance will pay and how much you will need to pay. This is just an estimate. We are not responsible if our estimate is incorrect. You are solely responsible for understanding your insurance benefits. It is important that you understand that in most cases your insurance is designed to reduce your cost, not eliminate it completely.

I agree to be responsible for all charges for dental services and materials not paid for by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Riding Plaza Dental Care.

I HAVE READ THIS POLICY CAREFULLY AND FULLY UNDERSTAND AND AGREE TO ALL ITS TERMS.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Riding Plaza Dental Care

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability and Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name: _____ Address: _____

Telephone: _____ E-mail: _____ Social Security #: _____

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether 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 matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of 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 revisions of our Notice, at any time by contacting:

Riding Plaza Dental Care- 25055 Riding Plaza, Suite 210 South Riding, VA 20152-(703) 327-9935

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.

Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to speak with regarding your appointments and treatment. Spouses are not automatically included; their names must be explicitly stated below.

I give the following named person(s) authorization to access my dental records:

Name of authorized person(s): _____ Relationship _____

Name of authorized person(s): _____ Relationship _____

CONSENT

I, _____ 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, complete the following:

Representative's Name: _____Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCATION OF CONSENT I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____