Welcome

Manassas Park Family Dentistry

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # ______
SS#/SIN ______
Date ______

Patient Information (CONFIDENTIAL)

Name ______ Birthdate ______ Home Phone ______
Address ______ City ______ State/Prov. ______ Zip/P.C. ______
Email ______ Cell Phone ______
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College ______ City ______ State/Prov. ______ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer ______ Work Phone ______
Business Address ______ City ______ State/Prov. ______ Zip/P.C. ______
Spouse or Parent/Guardian's Name ______ Employer ______ Work Phone ______
Whom may we thank for referring you? ______
Person to contact in case of emergency ______ Phone ______

Responsible Party

Name of Person Responsible for this Account ______ Relationship to Patient ______
Address ______ Home Phone ______
Email ______ Cell Phone ______
Driver's License# ______ Birthdate ______ Financial Institution ______
Employer ______ Work Phone ______ SS#/SIN ______
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured ______ Relationship to Patient ______
Birthdate ______ SS#/SIN ______ Date Employed ______
Name of Employer ______ Union or Local# ______ Work Phone ______
Address of Employer ______ City ______ State/Prov. ______ Zip/P.C. ______
Insurance Company ______ Group# ______ Policy/ID# ______
Ins. Co. Address ______ City ______ State/Prov. ______ Zip/P.C. ______
How much is your deductible? ______ How much have you used? ______ Max. annual benefit ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ______ Relationship to Patient ______
Birthdate ______ SS#/SIN ______ Date Employed ______
Name of Employer ______ Union or Local# ______ Work Phone ______
Address of Employer ______ City ______ State/Prov. ______ Zip/P.C. ______
Insurance Company ______ Group# ______ Policy/ID# ______
Ins. Co. Address ______ City ______ State/Prov. ______ Zip/P.C. ______
How much is your deductible? ______ How much have you used? ______ Max. annual benefit ______

Over Please

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with this practice."*
>
> *"It is our policy to provide a substitute health care provider, authorized by this practice, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to this practice for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Patient's Signature: Date:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES", revision date ____________________ .

As required by the Privacy Regulations, ____ from
Name of Staff Member

this practice has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- [ ] I wish to file a "Request for Restriction" of my Protected Health Information.
- [ ] I wish to file a "Request for Alternative Communications" of my Protected Health Information.
- [ ] I wish to object to the following in the "Notice of Privacy Practices":

____

____

I understand that this office may change their Notice of Privacy Practices and is not required to honor the terms of the original/previous version(s).

____ ________________________________
Signature Date

____
Print Name

____

(OFFICE USE ONLY)

Signed form received by: ____________________________________ Date: ________________________

Good faith effort to obtain receipt: (Describe) ____

____

____

©H.J. Ross Company, Inc. 2002, 2003 HIPAA Interactive-All Rights Reserved

ITEM 066-6289/18243 © JULY2003

Manassas Park Family Dentistry
9115 Andrew Dr. Manassas Park, VA 20111
703-530-9000

Patient Medical History

Physician ______________ Office Phone ______________ Date of Last Exam ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other ______________	☐	☐

Patient Dental History

Name of Previous Dentist and Location ______________ Date of Last Exam ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X ______________

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments ______________

____

Signature ______________ Date ______________

PATTERSON OFFICE SUPPLIES 1.800.637.1140 051-1055/16797

MEDICAL ALERT

Treatment Plan and Estimate

Date____________________

Patient Name____ Patient # ____________________________

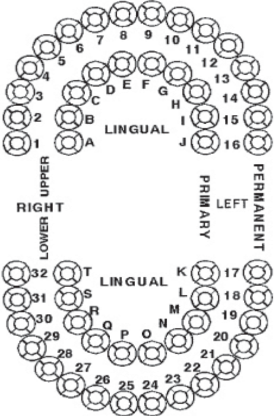
Insurance Carrier______________________________________ Policy # ____________________________

Tooth #	Surface	Treatment Recommendation	Dental Code	Estimated Fee	Estimated* Carrier Responsibility	Estimated Patient Responsibility	
						Option #1	Option #2
			DEDUCTIBLE	→	-$	+$	+$
			TOTALS	$	$	$	$

*This is an estimate of what you can expect your dental insurance to cover. The patient is responsible for any difference between actual charges and what the carrier pays.

These fees are valid for __________ days without reevaluation.

The above treatment recommendations have been explained to me. I have been informed of my dental condition, treatment options, benefits, risks and possible consequences of treatment as recommended, limited treatment or no treatment. My questions have all been answered. I accept the treatment plan recommended for Option _________.
It has been explained to me that as treatment is undertaken and proceeds, modifications of the above treatment plan and estimate may be necessary. Any treatment modification is to be discussed with me at the earliest convenient time.



____ ____________________
Patient/Guardian Signature (If a minor, parent or guardian must sign) Date

White - To patient Yellow - To insurance carrier

PATTERSON OFFICE SUPPLIES 1-800-637-1140 ITEM # 077-3374/9064 © 1993

Manassas Park Family Dentistry
9115 Andrew Dr. Manassas Park, VA 20111
703-530-9000

Patient Nam: --Date of Birth----------------------

Date	Tooth Number	Anesthetic Given	Treatment Missing Tooth Existing Restorations Treatment /Diagnostics	Dr/Ass /Hyg

Manassas Park Family Dentistry
9115 Andrew Dr. Manassas Park, VA 20111
703-530-9000