Fairlington Dental

4850 South 31st St. Ste. A * Arlington, VA 22206 * 703-671-1001

Patient Information

Patient Name: ______________________________ **Date:** __________

Last, First MI (Preferred Name)

Gender: Male / Female **Family Status:** Single / Married / Divorced / Widowed / Child

Birth Date: ______________________ **Social Security #:** ______________

Address: ____

Street Apartment #

____

City State Zip Code

Email Address: ______________________@____________

Phone (Home): ____________ **(Work)**: ____________ **Ext:** ______ **(Cell):** ____________

Best way to reach me is: ☐ Cell ☐ Work ☐ Home ☐ Email **Best time to reach me is:** ____________

Emergency Contact Information

Names and relationships of others who we may contact in case if an emergency (*does not live with you*):

Name: ____

Relationship: ____________________ Phone: ____________________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________ **Occupation:** ____________________

Address: ____

Street City, State Zip Code Phone

Dental Insurance Information

Primary Insurance Carrier: ______________ Subscriber Name: ______________ DOB: ______

Secondary Insurance Carrier: ______________ Subscriber Name: ______________ DOB: ______

Please provide insurance card at time of appointment so we may obtain required information for submitting a claim for your reimbursement.

Please tell us how you selected our office: *(Please mark all that apply)*

- ☐ Referred by Dr ____________________
- ☐ Referred by patient; ____________________
- ☐ Referred by FD Team: ____________________
- ☐ Google Search / Google Ad
- ☐ Angie's List
- ☐ Yelp.com
- ☐ Yahoo Search
- ☐ Facebook
- ☐ Fairlington Newsletter
- ☐ School Silent Auction
- ☐ Fairlington Dental Building Sign
- ☐ Fairlington Dental Website
- ☐ BriteSmile Website
- ☐ Dr. Oogle.com
- ☐ Other (Please specify) ____________________
- ☐ Other (Please specify) ____________________

Health Information

Date of Last Dental Visit: __________________ Reason for last visit: _________________________________

Please indicate YES for current medical conditions by marking the box beside each that apply:

- ☐ Adverse reaction to anesthetics
- ☐ AIDS / HIV
- ☐ Allergic to Penicillin
- ☐ Allergic to Amoxicillin
- ☐ Allergic to Clindamycin
- ☐ Allergic to Codeine
- ☐ Allergy Other ______________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bi-Polar Syndrome
- ☐ Blood Disease
- ☐ Cancer Type:__________
- ☐ Chest Pain / Angina
- ☐ CPAP Machine—Use Yes or No
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ Herbal Supplements
- ☐ Jaundice
- ☐ **Joint Replacement ****
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Phobia ______________
- ☐ Pregnancy, Possible
- ☐ Pregnancy, Confirmed
- ☐ Radiation Treatment
- ☐ Psychological Treatment
- ☐ Recreational Drug Use
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Smoker Amt per day ____
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Stomach Problems (including GERD)
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Premedication

*****You may need to pre-medicate prior to your dental appointments***

****Medication Name**	**Dosage / Frequency**	**Reason Taking Rx**

**Please include Herbal Supplements

Medical History

- Date of last complete physical: _______________ Doctor: ________________________
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- 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
  If yes, please explain: ____
- Name of Physician: ____ Phone: __________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

Dental History

Please Circle Yes or No:

- **Yes / No** Would you like to consider sedation dentistry for your treatment needs? It's as easy as taking a pill prior to your dental appointment. A team member will be happy to explain.
- **Yes / No** Would you like whiter teeth?
- **Yes / No** Do your gums bleed?
- **Yes / No** Are you concerned about your breath?
- **Yes / No** Do you have any sores or lumps in or near your mouth? If yes, where ______________
- **Yes / No** Do you snore while sleeping?
- **Yes / No** Have you been diagnosed with Sleep Apnea?
- **Yes / No** If you have Sleep Apnea, do you use a CPAP nightly?
- Do you have or have you ever had any of the following? (Please mark with an X)

___ *Pain in your jaw joints*

___ *Frequent Headaches*

___ *Clenching or grinding your teeth*

___ *Dental Phobia*

___ Change in bite / shifting teeth

___ *Soreness when chewing*

___ *Difficulty in opening or closing your mouth*

___ *Periodontal Treatment*

___ *Missing Teeth*

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________

Signature of patient, parent or guardian

FAIRLINGTON DENTAL

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices of Fairlington Dental. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary treatment, payment or office procedures.

____________________________________ ____________________________________
Print Name Address

____________________________________ ____________________________________
Signature Date

Please check your preferred means of communication (you may check more than one):

- ☐ You may contact me at my home telephone number __________________________
- ☐ You may contact me on my mobile telephone number __________________________
- ☐ You may contact me on my work telephone number __________________________
- ☐ You may send me an email at: ____
- ☐ Other ____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. ____Date Added / Removed:__________
2. ____Date Added / Removed: __________
3. ____Date Added / Removed: __________

* * *

For Office Use Only:
We 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 situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify) ____

Staff Person Initials ___________

Consent of Services

Please initial in each _____ below:

______ **Reserved Appointment Time:** Your appointment time is reserved especially for you. While we understand that certain emergencies may arise, we ask that you provide **3-business days notice** for cancellations or changes to your reserved appointment.

______ **Dental Insurance:** In order to maintain our high standard of care Fairlington Dental does not participate with insurance plans. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will prepare the patient's insurance forms in their entirety. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. We are happy to assist with dental / medical appeals should a charge be denied for payment, with the exception of exclusions by your dental / medical plan.

______ **Medicare Patients:** Our office has **opted out** of Medicare. By signing below, you agree to enter into a private contract with Dr Michael Rogers for services rendered. Upon signing below and entering this contract, you agree not to file Medicare for reimbursement or receive reimbursement from Medicare for the services rendered at our office.

______ **Payments:** Payment is expected at the time of service unless **prior** arrangements have been made. We accept American Express, MasterCard, Visa, Discover, Cash and Checks. We offer a 5% courtesy for any appointments exceeding $1000 when they are prepaid one week prior to the date reserved. We also offer flexible payment arrangements including interest free payments up to a year. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied. Returned checks will be subject to an additional fee of $30 per return. After a returned check, payment will need to be made with a credit card, cash, money order. No checks can be accepted after a returned item.

I understand that the fee estimates for dental care can only be extended for a period of **one month** from the date of the patient examination.

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

Dental Benefit Explanation

It is our policy to provide the best dentistry for you. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs and we assume that you are as concerned as we are about maintaining optimal dental health. Our entire team is pleased that you have insurance benefits to help you and your family with the cost of dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so we can work together to ensure these benefits.

Do you accept my insurance? We will gladly help file your insurance for reimbursement each time services are rendered. We are a non-participating office with all plans. As a courtesy, each time services are rendered we will generate a dental claim form, attach the necessary x-rays, narratives and/or photos and ask that you mail it to your insurance company. Your insurance company will process the claim based on the plan your employer has chosen. The payment will be mailed directly to you for reimbursement. Dental insurance is a contract between the employer and the patient. It has no connection at all to us as your dental office. The extent of coverage varies greatly from employer to employer, sometimes even so within a company. It has absolutely nothing to do with the level of service provided by us and the fee charged for our services. An often-misunderstood term used by many insurance companies is "UCR". This is an arbitrary fee ceiling at which the insurance company will stop reimbursement. These fee ceilings were often set 10-15 years ago. Your employer decides the level of coverage and benefits with your insurance company prior to the time that services are rendered by our office. Please check your plan for waiting periods or specific exclusions. We will be happy to provide dental codes and pricing upon request.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: _____________ Relationship to Patient: ___________

Signature of patient, parent or guardian

____ Date: _____________ Relationship to Patient: ___________

Signature of guarantor of payment/responsible party

Please list the name of specialists that you are currently working with or have worked with previously:

Patient's Name: ____

Date: ____________________

- **Physician:** ____

  City ______________________________ Phone: ___________________________

- **Previous/Current General Dentist:** ____

  City ____________________________ Phone: ___________________________

- **Osteopath:** ____

  City ___________________________ Phone: ____________________________

- **Physical Therapist:** ____

  City _______________________________ Phone: ____________________________

- **Cardiologist:** ____

  City ____________________________ Phone: ____________________________

- **Chiropractor:** ____

  City _____________________________ Phone: ___________________________

- **ENT:** ____

  City ___________________________________ Phone: __________________________

- **Other:** ____

  Specialty ____

  City ___________________________________ Phone: ___________________________

Patient's Name:_______________________

Date: _______________________

Sleep Apnea Preliminary Evaluation Form

The only way to be sure if you have obstructive sleep apnea is to have a sleep test either at home from a qualified sleep physician or in a hospital sleep center, but a score of 9 or above on this test is an indication that you should see your doctor.

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?
Choose the most appropriate number for each situation:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Activity	Score
Sitting and Reading	_____
Watching TV	_____
Sitting, inactive in a public place (theater, meeting, etc.)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total	_____