

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:

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

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

**Medication Name	Dosage / Frequency	Reason Taking Rx

**Please include Herbal Supplements

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.

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

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____