Patient Information

Patient Name: ____ Date: __________

Last, First MI (Preferred Name)

Gender: ____________ Family Status: ____________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): __________ (Work): __________ Ext: ______ (Cell): ______________

Email Address: ________________ @ __________

Address: ____

Street Apartment #

____

City State Zip Code

Spouse or Responsible Party Information (if not self)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): __________ (Work): __________ Ext: ______ (Cell): ______________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

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

Employer Name: ______________________ Occupation: ______________________

Address: ____

Street City, State Zip Code Phone

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: ____

____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Another patient, relative
☐ Dr. / Dental Office ☐ Magazine Ad ☐ TV Show ☐ School ☐ Work ☐ Other ______________________

Name of person or office referring you to our practice____

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:

- ☐ AIDS / HIV
- ☐ Allergies __________ __________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer,Type:_______
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Snoring
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Premedication

Current Medications:
____
____
____

- 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: ____

**Medication Name	Dosage / Frequency	Reason Taking Rx

**Please include Herbal Supplements

Dental History

Please Circle Yes or No:

- Would you like whiter teeth? Yes No (If yes, please feel free to ask any team member)
- Do your gums bleed? Yes No
- Are you concerned about your breath? Yes or No
- Do you have any sores or lumps in or near your mouth? Yes No If yes, where _______________
- Do you snore while sleeping? Yes No Have you been diagnosed with Sleep Apnea? Yes No
- Do you have or have you ever had any of the following? (Please mark box)
  - ☐ Pain in your jaw joints
  - ☐ Soreness when chewing
  - ☐ Frequent Headaches

☐ Difficulty in opening or closing your mouth
☐ Clenching or grinding your teeth
☐ Periodontal Treatment

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.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the 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.

____ **Dental Insurance:** 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 patients 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.

____ **Medicare Patients:** Our office has **opted out** of Medicare. By signing below, you agree to enter into a private contract with Dr Michael Rogers and Dr Dennis Holly 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 60 days, unless previously written financial arrangements are satisfied.

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 prior if necessary.

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 General Dentist:** ____

  City ________________________________ Phone: _____________________________

- **Osteopath:** ____

  City _____________________________ Phone: ______________________________

- **Physical Therapist:** ____

  City _________________________________ Phone: ______________________________

- **Cardiologist:** ____

  City ______________________________ Phone: ______________________________

- **Chiropractor:** ____

  City _______________________________ Phone: _____________________________

- **ENT:** ____

  City _____________________________________ Phone: ____________________________

- **Other:** ____

  Specialty ____

  City _____________________________________ Phone: _____________________________

Nighttime Sleepiness Evaluation

Screening Tool for Sleep Apnea

1. **Snoring**
   a. Do you snore on most nights? (>3 times per week)?
      Yes (2) No (0) ________

   b. Is your snoring loud? Can it be heard through a door or wall?
      Yes (2) No (0) ________

2. **Has it ever been reported to you that you stopped breathing or gasp during sleep?**
   Never (0) Occasionally (3) Frequently (5) ________

3. **What is your collar size?**

   <u>Male:</u> Less than 17 inches (0) More than 17 inches (5) ________

   <u>Female:</u> Less than 16 inches (0) More than 16 inches (5) ________

4. **Do you occasionally fall asleep during the day when:**
   a. You are busy or active?
      Yes (2) No (0) ________

   b. You are driving or stopped at a light?
      Yes (2) No (0) ________

5. **Have you had or are you being treated for high blood pressure?**
   Yes (1) No (0) ________

TOTAL: ________

Score

9 points or more	**6-8 points**	**5 points or less**
Refer to sleep specialist or order sleep study	Gray area, Use clinical judgment	Low probability of sleep