Patient Information

Date:_____

Title & Name:_____ Preferred Name: _____

DOB: _____ Marital Status: _____ Sex: _____

Address: _____ City, State, Zip: _____

Home Ph:_____ Work Ph: _____ Cell: _____

E-mail:_____ Best Way/Number to Reach You:_____

SSN:_____ Emergency Contact:_____ Ph: _____

Preferred Pharmacy & Location (City):_____ Ph:_____

Employer:_____ Occupation:_____

Whom May We Thank For Referring You To Our Office?_____

Members of Family Being Treated in our Office:_____

INSURANCE: Please complete so we may assist you in receiving your insurance benefits

Insurance Policy Holder:_____ Policy Holder DOB: _____/_____/_____ ID/SSN:_____

Employer:_____ Insurance Company:_____ Group #:_____

Claims Mailing Address:_____ Eligibility #:_____

Dental History

Chief Concern for Today's Visit: _____

When Was Your Most Recent Dental Visit?: _____ Dentist Name & Specialty:_____

Were X-Rays Taken?:_____ Were You Covered Under The Same Dental Insurance During That Visit?_____

How Would You Describe Your Dental Health? (Please Check One):_____ Excellent _____ Good _____ Fair _____ Poor

What rating would you give your teeth on a scale of 1 – 10? (1 being poor and 10 being excellent) _____

What priority would you give your teeth on a scale of 1 – 10? (1 being low and 10 being high) _____

Do You Gag Easily During: (Please Check All That Apply) _____ X-Rays _____ Impressions _____ Procedures _____ Other: _____

Do You Have Any Of The Following?: (Please Check All That Apply) ___ Sensitive Teeth ___ Bleeding Gums ___ Clenching and/or Grinding ___ Dry Mouth ___ Pain and/or Discomfort in Your Mouth ___ Biting of Cheeks ___ Unpleasant Taste or Odor ____ Loose Teeth

Has Your Smile Changed in the Last Five Years?: ____ Yes ____ No; if 'Yes', Please Describe: _____

_____

Is There Anything You Would Change About Your Smile? (Please Describe)_____

_____

Do You Wish To Speak With The Doctor Privately About Any Cares or Concerns? _____ Yes _____ No

I will allow Centreville Dental Wellness Center, PC to discuss my condition(s) with my physician and/or other treating providers and to request information from them as necessary. _____ (initial)

I will allow Centreville Dental Wellness Center, PC to photograph and use for educational and marketing purposes any aspects of my dental condition(s) or treatment procedures. _____ (initial)

Signature Date

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6.	Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE			
7.	Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8.	Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?	☐	☐
13.	Have you experienced a burning, painful sensation, or metallic taste in your mouth?	☐	☐
TOOTH STRUCTURE			
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT			
21.	Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS			
33.	Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34.	Have you ever bleached (whitened) your teeth?	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury _____
2. an allergic or bad reaction to any of the following:
   - aspirin, ibuprofen, acetaminophen, codeine _____
   - penicillin _____
   - erythromycin _____
   - tetracycline _____
   - sulfa _____
   - local anesthetic _____
   - fluoride _____
   - chlorhexidine (CHX) _____
   - Iodine _____
   - metals (nickel, gold, silver, _____)
   - latex _____
   - nuts _____
   - fruit _____
   - milk _____
   - red dye _____
   - other _____
3. heart problems, or cardiac stent within the last six months _____
4. history of infective endocarditis _____
5. artificial heart valve, repaired heart defect (PFO) _____
6. pacemaker or implantable defibrillator _____
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) _____
8. heart murmur, rheumatic or scarlet fever _____
9. high or low blood pressure _____
10. a stroke (taking blood thinners) _____
11. anemia or other blood disorder _____
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____
14. chronic ear infections, tuberculosis, measles, chicken pox _____
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____
17. kidney disease _____
18. liver disease or jaundice _____
19. vertigo (e.g. "the room is spinning") _____
20. thyroid, parathyroid disease, or calcium deficiency _____
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) _____
22. high cholesterol or taking statin drugs _____
23. diabetes (HbA1c = _____) _____
24. stomach or duodenal ulcer _____
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____
27. arthritis or gout _____
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____
29. glaucoma _____
30. contact lenses _____
31. head or neck injuries _____
32. epilepsy, convulsions (seizures) _____
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _____
34. viral infections and cold sores _____
35. any lumps or swelling in the mouth _____
36. hives, skin rash, hay fever _____
37. STI/STD/HPV _____
38. hepatitis (type ____) _____
39. HIV/AIDS _____
40. tumor, abnormal growth _____
41. radiation therapy _____
42. chemotherapy, immunosuppressive medication _____
43. emotional difficulties _____
44. psychiatric treatment or antidepressant medication _____
45. concentration problems or ADD/ADHD _____
46. alcohol/recreational drug use _____

ARE YOU:

47. presently being treated for any other illness _____
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____
49. taking medication for weight management _____
50. taking dietary supplements, vitamins, and/or probiotics _____
51. often exhausted or fatigued _____
52. experiencing frequent headaches or chronic pain _____
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____
54. considered a touchy/sensitive person _____
55. often unhappy or depressed _____
56. taking birth control pills _____
57. currently pregnant _____
58. diagnosed with a prostate disorder _____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)**

Centreville Dental Wellness Center, PC
14245-F Centreville Square
Centreville, VA 20121
703-815-0775
dentalwellnessctr@gmail.com

Important Information and Financial Policy

We welcome and value you as part of our dental practice. In order to avoid confusion regarding our financial and insurance policies; please review this document and sign it as acceptance and understanding of what is stated. Our practice accepts cash, check, VISA, MC, Discover, AMEX & Debit cards. If you have any questions, please speak with our office manager.

Today's dental plans are designed to assist patients with dental treatment. It is important to remember that necessary services are not necessarily covered. Our goal as your dental care provider is to make sure you have healthy teeth long after you change dental plans. It is your employer who chooses your benefits and how they are paid by the insurance company.

PLEASE INITIAL THE SCENARIO THAT DESCRIBES YOUR FINANCIAL/INSURANCE SITUATION. ALL OUTSTANDING BALANCES ARE DUE IMMEDIATELY ON THE DATE OF SERVICE:

_____ I **do not** have dental insurance. I am responsible to pay my bill in full at each visit. The practice's personnel will give me information on outside financing if I request it.

_____ I understand the practice doctors are participating providers for my dental plan (**Aetna, Cigna, Delta Dental Plus Premier, and United HealthCare (Dr. Abel ONLY).** I am required to pay my estimated portion of the dental fee at each visit for the treatment rendered that day. The amount I will be required to pay will be explained to me prior to my appointment. I also understand that my insurance is an agreement between the insurance company and me; therefore, if the practice does not receive payment from my company in 90 days, the insurance balance for my account will be transferred to me personally and needs to be paid promptly, or an 18% interest charge will be added.

_____ I understand the practice doctors are **not** a participating provider for my dental benefit company and assignment of benefits will be paid directly to me. I understand that I am responsible for my account regardless of my insurance status.

PLEASE READ AND INITIAL EACH FOLLOWING STATEMENT BELOW:

_____ I understand that dentistry is not an exact science so my treatment may need to be altered at the time of appointment. I will still need to pay my portion of the visit if different from the original estimate. If the final payment from the insurance carrier is less than the estimated amount, I will assume financial responsibility for the entire not covered balance. The practice does not guarantee any actual payments made by your insurance company. The estimated amount due does not take into account insurance deductibles or changes in the payment allowance as delineated by your contract at the time of insurance payment.

_____ All major dental treatment must be paid in full prior to being inserted in your mouth. If I have insurance that the practice accepts, I must pay my portion in full as estimated by the office. I am aware that if my insurance denies my dental claim, the office will file an appeal on my behalf. The office will only file one appeal, if there, insurance denies the claim again, I will have to file the appeal myself and will be responsible for my balance in the office. I may request information to file an appeal from the office.

_____ After two attempts are made via postal mail invoices to collect your account balance, a final notice letter will be sent to any account with an outstanding balance of 90 or more days. If the balance is not paid in full within 30 days, it will be referred to a debt collection agency. At that time, a processing fee of 35% will be added to your account balance. Once your account has been referred to the debt collection agency, we will no longer be able to help you work out a payment plan.

_____ In order for us to service your account and/or to collect any amounts owed to us, you authorize Centreville Dental Wellness Center and its affiliates, such as third-party debt collection agencies, to contact you at any telephone number associated with your account that you have provided on your patient registration. Methods of contact include, but are not limited to, pre-recorded voicemail messages, automatic telephone dialing systems, and automated SMS text-message reminders.

*****SIGNATURE NEEDED, PLEASE SEE BACK SIDE OF THIS FORM →**

_____ I must respect doctors and hygienist's schedule and will give **48-hour notice** if I need to change my appointment time, otherwise I will be charged $80.00. I also understand that for longer appointments, this charge may be higher. It is important to be on time for your appointment, so we have the full amount of time to dedicate to your care.

_____ I give permission for my dentist or his/her associates and clinical team to take any necessary radiographs (x-rays), study casts, and photographs needed to make a complete diagnosis for my dental needs. I also give permission to use this information for in-office educational purposes.

If you want to leave your minor children at the office for treatment without your presence, please read and initial below:

_____ I give my permission to treat my minor child/children in my absence, whether I drop them off for treatment or another adult brings them to the office for treatment. I will give my child a check or credit card information to fulfill the amount due for their treatment.

If you have an adult child (over 18) and will continue to be financially responsible for their treatment please read, fill in child's name, and initial below:

_____ I will continue to be financially responsible for (fill in child's name) _____. If I have insurance, I will provide my insurance company with the necessary documentation that they are a full-time student.

I have read, agreed to, and understand the statements listed above. If I request, I may receive a copy of this document for my records.

_____	_____ _____	_____/_____/_____
Patient Printed Name	Signature (parent, legal guardian if minor)	Date

Centreville Dental Wellness Center
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Centreville, VA 20121
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Dentalwellnessctr@gmail.com

Notice of Our HIPAA Privacy Practices

Understanding Your Health Record & Information

Each time you visit our office a record of your visit is made. Typically, this record contains your symptoms, examination, diagnosis, treatment, and plan for future treatment. This is considered your health record and serves as a basis for planning your future care and treatment. We also keep all communication sent to us from other health care professionals on your behalf. Unless otherwise required, by law your health record is the physical property of our office; all information complied belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of your health record.

Who May We Disclose Your Information To?

- **Personal Correspondence:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Family Members:** We may share your health records with any person you have specifically authorized us to discuss with or release your treatment or you have requested we send your record to.
- **Healthcare Professionals:** we may share your health record with any doctor with whom we coordinate your treatment or you have requested we send your record to. We will use our professional judgment in any emergency situations.
- **Law Enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
- **Public Health:** As required by law, we may disclose your health information to public health or legal authorities charged with tracking births and deaths, as well as preventing or controlling disease, injury, or disability.
- **Collection Agency:** In the event of payment delinquency,if a collection agency is used, we will give them only the information necessary to collect the debt.

Maintaining Your Privacy

- We shred information that may contain protected healthcare information that is not necessary to keep.
- We employ firewalls and passwords to protect your information from unauthorized individuals.
- We educate our staff as to the importance of protecting health care information
- We require written authorization prior to disclosing information to sources not defined in this document

If you have any questions or concerns regarding our privacy practices, please contact our front desk.

Centreville Dental Wellness Center
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Centreville, VA 20121
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Dentalwellnessctr@gmail.com

ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES

I, _____, have read a copy of this office's Notice of HIPAA Privacy Practices.

_____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of HIPAA 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 acknowledgement
- □ Other (please specify):

_____

_____

_____