



Welcome To Our Practice!

Please take a few minutes to answer the following questions so we may better assist you with your dental needs.

Guest Information:

Today's Date: _____

Name: _____
Last First Middle Initial Goes by: _____

Sex: M _____ F _____ Married _____ Single _____ Child _____ Other _____ Birthday: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Guest's Employer/School: _____ Occupation: _____

Email address: _____

In case of emergency, whom should we notify? _____

Relation: _____ Phone: _____

Whom may we thank for referring you to our practice?

Friend/Family Member ☺: _____

Newspaper _____ Internet Website (please be specific) _____

Postcard _____ Phonebook: _____ Other: _____

Who is responsible for this account?

Me: _____ Other: _____
Last First Phone: _____

Relationship to Patient: _____ Birthdate: _____

Address (if different from above): _____ City: _____ State: _____ Zip: _____

Employer: _____

Primary Dental Benefit Information:

Benefit Provider: _____ Employer: _____

Provider Address: _____ City: _____

State: _____ Zip: _____ Provider Phone Number: _____

Subscriber ID #: _____ Group #: _____ Benefit renewal month: _____

Health History:

Do you or have you ever had any of the following?:

- | | | |
|--|---|---|
| <input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Adrenal/Pituitary Problems
<input type="checkbox"/> AIDS/HIV+
Year diagnosed: _____
<input type="checkbox"/> Alcohol Addiction
<input type="checkbox"/> Allergies (seasonal/pets)
<input type="checkbox"/> Anemia
<input type="checkbox"/> Angina
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Arthritis
Year diagnosed: _____
Affected areas: _____
<input type="checkbox"/> Artificial Heart Valve(s)
<input type="checkbox"/> Artificial Joints
Year of replacement: _____
Joint(s): _____
<input type="checkbox"/> Asthma
Carry inhaler? Y _____ N _____
Induced by? _____
<input type="checkbox"/> Bleeding Disorders
<input type="checkbox"/> Blood Transfusion
Year: _____
<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Cancer:
Year diagnosed: _____
Type: _____ | <input type="checkbox"/> Chemotherapy
Year: _____
<input type="checkbox"/> Cold Sores
<input type="checkbox"/> Congenital Heart Lesions
<input type="checkbox"/> Cortisone Treatment
Date of last treatment: _____
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
Type 1 _____ Type 2 _____
Year Diagnosed: _____
<input type="checkbox"/> Drug Addiction OR <input type="checkbox"/> Drug Use
<input type="checkbox"/> Eating Disorder:
Anorexia _____ Bulimia _____
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Gastrointestinal/Stomach Problems
<input type="checkbox"/> Heart Attack
Year: _____
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Failure
<input type="checkbox"/> Heart Murmur or Arrhythmia
<input type="checkbox"/> Heart Pacemaker
<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Hepatitis
Type A _____ B _____ C _____
Year Diagnosed: _____ | <input type="checkbox"/> Herpes
Type: _____
<input type="checkbox"/> High Blood Pressure
Year Diagnosed: _____
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Kidney Disease/Dialysis
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Osteoporosis ___ Osteopenia ___
<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Radiation
Year: _____
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Sickle Cell Disorder
<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Stroke
Year: _____
<input type="checkbox"/> Thyroid Disease:
Hypo _____ Hyper _____
<input type="checkbox"/> Tobacco Use:
Smoke ___ Dip ___ Pipe ___
Snuff ___ Snuss ___
Year Started _____ Year Quit _____
Packs/# times per Day: _____
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Vaping |
|--|---|---|

Women:

Are you taking birth control: Yes _____ No _____
 Taking Hormonal Medications: Yes _____ No _____
Pregnant: Yes _____ No _____
 If yes, due date: _____
Nursing: Yes _____ No _____

Dental History:

Date of your last dental visit? _____
Are you currently experiencing any discomfort? Yes _____ No _____
Have you experienced any of the following?

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Clicking/popping of jaw	<input type="checkbox"/> Grinding/clenching	<input type="checkbox"/> Orthodontic treatment
<input type="checkbox"/> Bleeding or swollen gums	<input type="checkbox"/> Do you wear a nightguard?	<input type="checkbox"/> Jaw pain	<input type="checkbox"/> Periodontal (gum) treatment
<input type="checkbox"/> Burning sensation on tongue	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Mouth breathing	<input type="checkbox"/> Sensitivity to hot &/or cold

●●● **Do you LOVE going to the dentist?** Yes _____ No _____ ●●●

Medications:

Please list any medications you take or drugs you use, recreational or otherwise:

Allergies:

- Acrylic Aspirin Codeine Erythromycin
 Latex Penicillin/Amoxicillin Sulfa Other: _____

Have you had any reactions to jewelry or do you have any metal allergies? Yes _____ No _____

Describe any serious trouble you have had with previous dental treatment:

Please list any other conditions or health concerns we should know about:

Consent for Services/Appointment & Financial Policies:

- It is Dr. Bambrey's and her team's mission to provide the highest quality dental care for our patients. We are committed to the success of your oral health. In an effort to keep our fees affordable, we have adopted a **fee-for-service** policy. **Payment for ALL services, other than Preventive or Diagnostic care, is due IN FULL at the time treatment is rendered** (excluding Delta & Cigna members). **Patients will be reimbursed directly from their benefit provider.** We accept cash, personal checks, Visa, MasterCard, Discover, Debit cards, and Care Credit, our interest-free payment plan.
- We will submit all claims for you and make every effort to closely estimate what your benefit reimbursement will be for your treatment, but this is **NOT** a guarantee of coverage. Your benefits are based solely on an agreement between your employer and the benefit provider. Therefore, there is a wide variety of rules and exclusions that allow your benefit provider to underpay or deny payment! If your benefit provider denies or does not cover the provided service(s), or does not make payment within 60 days of treatment, the balance is **your** responsibility. It is also **your** responsibility to know your plan benefits and to inform us when any changes to your coverage occur.
- A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 (sixty) days. In the event of a default, the patient or responsible party shall be responsible for paying all collection costs and reasonable attorney fees if suit be instituted hereunder.
- The patient or responsible party hereby authorizes Dr. Bambrey and her team to:
 - *take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Bambrey to make a thorough diagnosis of my, or the patient's, dental needs.
 - *perform any dental treatment and utilize any medication that may be indicated, with the understanding that all dental procedures and use of anesthetic agents and other medicaments carry a certain risk.
 - *choose and employ such assistance as deemed necessary and appropriate.
- I also understand that during the course of the proposed treatment unforeseen conditions may arise, requiring the performance of additional procedures. I authorize these changes to be performed and fully acknowledge there will be additional fees for which I will be responsible.
- I grant my permission to Dr. Bambrey or her assignee to contact me by phone at home, work, or on my cell, or via email to discuss matters related to my dental care or remind me of an upcoming appointment.
- **I understand that failure to give 48 business hours notice (2 business days) of any appointment I am unable to keep will result in a \$50 missed appointment fee, per hour of reserved time. (Please consider your calendars carefully when scheduling.)**
- Your signature below indicates that you have read the above conditions of treatment and payment, and agree to their content, intending to be legally bound.

Signature of Patient or Responsible Party

Date

Dina Bambrey, DMD, FAGD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

SECTION B: TO THE PATIENT---PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Dina Bambrey

Telephone: 703-726-9119 Fax: 703-726-9244

Address: 44025 Pipeline Plaza, Suite 120 Ashburn, VA 20147

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that *we may decline to treat you or to continue treating you if you revoke this Consent.*

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.**

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.