Welcome To ☺ur 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: ______________________________ Goes by: ____________________
Last First Middle Initial

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: ______________________________ Phone: ____________________
Last First

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?:

☐ADD/ADHD
☐Adrenal/Pituitary Problems
☐AIDS/HIV+:
Year diagnosed: ______________
☐Alcohol Addiction
☐Allergies (seasonal/pets)
☐Anemia
☐Angina
☐Anxiety
☐Arthritis:
Year diagnosed: ______________
Affected areas: ___________________
☐Artificial Heart Valve(s)
☐Artificial Joints:
Year of replacement: ______________
Joint(s): _______________________
☐Asthma:
Carry inhaler? Y_______ N _______
Induced by? ____________________
☐Bleeding Disorders
☐Blood Transfusion:
Year: ______________
☐Bruise Easily
☐Cancer
Year diagnosed: ______________
Type: ___________________________

☐Chemotherapy:
Year: ______________
☐Cold Sores
☐Congenital Heart Lesions
☐Cortisone Treatment:
Date of last treatment: ______________
☐Depression
☐Diabetes:
Type 1 _______ Type 2 _______
Year Diagnosed: ______________
☐Drug Addiction ***OR*** ☐Drug Use
☐Eating Disorder:
Anorexia _______ **Bulimia** _______
☐Emphysema
☐Epilepsy/Seizures
☐Glaucoma
☐Gastrointestinal/Stomach Problems
☐Heart Attack:
Year: ______________
☐Heart Disease
☐Heart Failure
☐Heart Murmur or Arrythmia
☐Heart Pacemaker
☐Hemophilia
☐Hepatitis:
Type A ______ B ______ C ______
Year Diagnosed: ______________

☐Herpes:
Type: ____________________
☐High Blood Pressure:
Year Diagnosed: _____________
☐High Cholesterol
☐Kidney Disease/Dialysis
☐Liver Disease
☐Mitral Valve Prolapse
☐Osteoporosis___ Osteopenia ___
☐Psychiatric Treatment
☐Radiation:
Year: ______________
☐Rheumatic Fever
☐Rheumatism
☐Scarlet Fever
☐Sickle Cell Disorder
☐Sinus Trouble
☐Stroke:
Year: ______________
☐Thyroid Disease:
Hypo _______ Hyper _______
☐**Tobacco Use:**
Smoke ____ Dip ____ Pipe ____
Snuff _____ Snuss _____
Year Started _____ Year Quit _____
Packs/# Times Per Day: ___________
☐Ulcers
☐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?

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

●●●Do you L☺VE going to the dentist? Yes ______ No ______ ●●●

Medications:

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

____

____

____

Allergies:

☐Acrylic	☐Codeine	☐Latex	☐Sulfa
☐Aspirin	☐Erythromycin	☐Penicillin/Amoxicillin	☐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

HIPAA Release Form

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 ill 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.

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**In non "legal" language, this means we can only use your information to file your benefits, provide dental care to you, collect our fee and communicate with other health care providers that we have referred you to.