WELCOME TO OUR OFFICE

Patient Name: ______________________________ Date __________ Birth Date_________
Last First MI
Address____

Phone Numbers: Home___________________ Cell_________________Work___________________
Email Address________________Do you prefer confirmation through email?___ Marital Status______

Health Information

Date of Last Dental Visit: _________________ Reason for this visit:_________________________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
( ) Being treated?
☐ Allergies (non drug)
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints: _____
Surg Date: ________
☐ Asthma
☐ Blood Disease: _____
☐ Cancer: Type; When
____
☐ Cholesterol
☐ Diabetes:Type: _____
* HbA1c:(6)(7)(7-9)(>9)
Date HbA1c test:____

☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma (Acute<?)_
☐ Growths
☐ Hay Fever/Seasonal
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur/Defect
Type: ____________
☐ Hepatitis -Type: ____
☐ High Blood Pressure
☐ Immune Disorders
☐ Kidney Disease

☐ Liver Dis, Jaundice
Type: ____________
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_________
☐ Radiation Treatment
☐ Reflux/GERD
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sex Trans Disease
☐ HPV
☐ Sinus Problems
☐ Stomach Problems

☐ Stroke: when:_____
☐ Tobacco: Amount?__
☐ Thyroid: Type ______
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Angina
( ) Frequency Change?
( ) Change in severity?
( ) Angina at rest?
( ) BreakthroughAngina?
☐ Heart Attack/MI
When?___________
Other we should know?

What medications, drugs, or pills are you allergic to ? ________________________________

- Do you take any prescription medications or herbal supplements?___ (please list them on the medications page)
- Have you had a Full Mouth Series of dental x-rays or Panograph taken? [yes no] When last?________
- Do you have any problems chewing gum, or hard to chew foods like bagels?__________________________
- Have your teeth changed in the last 5 years? ____
- Do you have more than one bite? ____________________Are you happy with your smile/look?______________
- Do you sleep restlessly? ____
- Have you ever had any complications following dental treatment? ☐ No ☐ Yes

  If yes, please explain:____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ No ☐ Yes

  If yes, please explain:____
- Are you now under the care of a physician? ☐ No ☐ Yes

  If yes, please explain:____
- When was your last medical exam? _________________ What is your Blood Pressure? __________________

Name of Physician: ____Phone:________________________

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 doctor(s) at the next appointment without fail.

____ Date: ____________________
Signature of patient, parent or guardian

From whom did you hear about our office?____

2-Form HH 090522

MEDICATIONS (Including over-the-counter)

Patient Name:_________________________ Date:___________

Updated _____ _____ _____ _____ _____ _____

Brand Name	Generic Name	Purpose	Doctor Prescribing	Dr. Phone
DRUG ALLERGIES				

Mark G. Smith, D.D.S.

Financial Arrangements - Broken Appointment Information - Truth in Lending Statement

It is the policy of this office to collect payment for services as they are rendered. Patients with insurance benefits are expected to pay their estimated portion and deductible at the time of service. A minority of insurance plans send benefits directly to the patient. In that event, the patient will pay in full and be reimbursed by their insurance carrier. This office is not a preferred provider for **any** insurance company. Dental insurance benefits are an agreement between you, your employer, and the insurance company. As a courtesy for our patients we prepare and file the insurance claims.

While we are sensitive to divorce situations, our policy is to hold the parent seeking treatment for their child responsible for any charges not covered by insurance.

Payment Options

- We accept cash, checks, and Visa, MasterCard, and Discover credit or debit cards.
- For payment plan options ask us about **Care Credit**. We are pleased to offer 3 month or 6 month interest free financing for balances over $300. Extended payment options are also available.
- All financial questions or special arrangements **MUST** be made at least 48 hours before your appointment.

Broken Appointment Information

The time for your dental appointment has been reserved exclusively for you. We request 48 hours notice to reschedule an appointment.

- A minimum fee of $50.00 may be charged for missing an appointment or for changing an appointment without adequate notice.

Practice Dismissal

Occasionally, we may find it necessary to dismiss a family from the practice. Reasons for this include, but are not limited to, the following:
recurrent late or missed appointments; noncompliance with recommended dental care; nonpayment of bills; threatening, abusive, or rude behavior toward office staff, doctors, or other patients and families.

I have read and understand all policies mentioned herein. I understand Dr. Smith does not have a contract with any insurance company, and I am responsible for all incurred fees.

Overdue Accounts

Unpaid balances exceeding 30 days will be charged ***1½% per month*** (18% per annum). The patient or guardian shall be responsible for all reasonable collection and attorney costs if they become necessary.

Signature____ Date ____________________

Mark G. Smith, D.D.S.

Responsible Party Information

The following is for: ☐ the patient ☐ the person responsible for payment (relationship to patient: ______________________)

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _________________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ________________ (Work): ________________ Ext:______ Best time to call: ______________

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

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: ____

____

Mark G. Smith, D.D.S.
201 North Maple Avenue, Suite 202
Purcellville, Virginia 20132

INSURANCE INFORMATION

- Dental benefits are not meant to determine your dental care but are to assist you in the payment of your treatment.
- We are not responsible for determining what your particular benefits are. Most policies cover what they consider a "usual and customary fee." However, insurance companies establish the UCR fee schedule relative to the premium charged for a particular plan. They are not always the same as the fees charged by our office.
- We will do our best to see that you receive your full benefits. However, ultimate responsibility for payment is yours, and financial arrangements must be defined before dental treatment begins.
- You are responsible for portions not covered by your policy on the day of service.
- Your insurance policy is a contract between you and your insurance company. Any problems of non-payment or a delay of payment are your responsibility.
- Any insurance balance over 30 days old is delinquent and is your responsibility to pay.
- Accident insurance cases will be handled by the patient paying for treatment at time of service, and the insurance company reimbursing the patient.

RELEASE OF INFORMATION

I authorize the release of any dental information necessary to process this claim for family members or myself.

Signed:_____________________________________Date:__________

ASSIGNMENT OF BENEFITS

I authorize payment of dental benefits to the named provider for professional services rendered to my family members or me.

Signed:_____________________________________Date:__________

Mark G. Smith, D.D.S.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 per page in text and $5.00 per page for x-rays or photographs, $35.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Kim Ent (540) 338-9400
201 N. Maple Ave., Suite 202
Purcellville, VA 20132