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team@loudoundentalassociates.com

	INEVV PA		REGISTR/	ATION	
FIRST NAME	LAST NAME			MIDDLE INITIAL	BIRTH DATE
ADDRESS					
CITY			STATE	ZIP	
PHONE (H)	(C)		EMAIL		
SOCIAL SECURITY NUMBER			DRIVERS LICEN	NSE NUMBER	
SEX: M F	IS PATIENT PO	LICY HOLI	DER? Y	N	
EMERGENCY CONTACT NAME			E	MERGENCY CONTACT	PHONE
RESPONSIBLE PART	TY INFORMATION ((IF SO	MEONE OT	HER THAN PA	TIENT) BIRTH DATE
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ADDRESS			STATE	ZIP	
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SOCIAL SECURITY NUMBER			DRIVERS LICE	NSE NUMBER	
SEX: M F		RELA	TIONSHIP TO PAT	IENT SPOUSE	CHILD OTHER
PRIMARY INSURANC	E INFORMATION				
EMPLOYER		EMPL	OYER ADDRESS		
DENTAL INSURANCE CO.					
GROUP NUMBER	MEMBER ID				
SECONDARY INSURA	ANCE INFORMATION	ON			
EMPLOYER		EMPL	OYER ADDRESS		
DENTAL INSURANCE CO.					

NEW PATIENT REGISTRATION

Do you use tobacco? Y N If YES:	PATIENT NAME		ВІ	RTH DATE				CREATION DATE	
rmedication you may be faking, can impact your dental health. EDICAL HISTORY Are you under a physicion's care now? Y N If YES: Have you ever been hospitalized or had a major surgery? Y N If YES: Do you take, or have you taken, Phen-Fen or Redux? Y N If YES: Do you take, or have you taken, Phen-Fen or Redux? Y N If YES: Do you take, or have you taken, Phen-Fen or Redux? Y N If YES: Do you take, or have you taken, Phen-Fen or Redux? Y N If YES: Do you take, or have you taken, Phen-Fen or Redux? Y N If YES: Do you use to tobacco? Y N If YES: Do you use controlled substances? Y N If YES: WOMEN: Are you Pregnant/Trying to get pregnant? Nursing? Taking Oral Contraceptives? WOMEN: Are you allergic to any of the following? Aspirin Penicillin Penicil	Although dontal pareappol	orimarily t	troat the area in and aroun	nd vour mo	uth vou	mouth is a part of	vour ontiro k	pody. Hoalth problems that you	ı may hay
Are you under a physicion's care now? Y N If YES: Have you ever been hospitalized or had a major surgery? Y N If YES: Are you take or have you taken. Phen-Fen or Redux? Y N If YES: Do you take, or have you taken. Phen-Fen or Redux? Y N If YES: Have you ever had a serious head or neck injury? Y N If YES: Do you take, or have you taken. Phen-Fen or Redux? Y N If YES: Do you take, or have you taken. Phen-Fen or Redux? Y N If YES: Do you take taken Fosamac. Bonks. Actonel or any other Y N If YES: Do you use tobacco? Y Y N If YES: Do you use tobacco? Y Y N If YES: Do you use tobacco? Y Y N If YES: Do you use tobacco? Y Y N If YES: Do you use tobacco? Y Y N If YES: Do you use tobacco? Y Y N If YES: Do you use tobacco? Y Y N If YES: Do you use tobacco? Y Y N If YES: Do you use tobacco? Y Y N If YES: Do you use tobacco? Do you use tobacco? Y N If YES: Do you ase to	or medication you may be t	aking, ca	n impact your dental heal	th.	utii, youi	mouth is a part of	your entire t	oody. Health problems that you	u IIIay IIa
Have you ever had a serious head or neck injury? Y N If YES: Are you taking any medications, pills or drugs? Y N If YES: Do you take, or have you taken, Phen-Fen or Redux? Y N If YES:		's care no	w?	Y N	If YES:				
Are you taking any medications, pills or drugs? Y N If YES: Do you take, or have you taken, Phen-Fen or Redux? Y N If YES:	Have you ever been hospi	talized or	had a major surgery?	Y N	If YES:				
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Have you ever taken Fosamax, Boniva, Actonel or any other Y N If YES: Are you on a special diet?	Are you taking any medica	itions, pill	s or drugs?	Y N	If YES:				
medications containing bisphosphonates? Are you on a special diet? Do you use tobacco? Y N If YES: Do you use controlled substances? WMMEN: Are you Pregnant/Trying to get pregnant? Nursing? Taking Oral Contraceptives? Are you altergic to any of the following? Aspirin Penicillin Codeine Acrylic Acrylic Metal Latex Sulfia Drugs Local Anesthetics DENTAL HISTORY Do you have, or have you had, any of the following? NIDSHIN Positive Y N Hemophilia Y N Rediation Treatments Y N Hepatitis B or C Y N Recent Weight Loss Y N Anaphalaxis Y N Drug Addiction Y N Hepatitis B or C Y N Renal Dialysis Y N Hemophilia Y N Easily Winded Y N Hepatitis B or C Y N Remal Dialysis Y N Hendial South Y N Excessive Bleeding Y N High Blood Pressure Y N High Blood Pressure Y N Scarle Fever Y N Antificial Idnit Y N Excessive Bleeding Y N Hives or Rash Y N Scarle Fever Y N Hives or Rash Y N Sickle Cell Disease Y N Fequent Clough Y N Hives or Rash Y N Spinas Bifdia Y N Excessive Thirst Nathma Y N Fequent Diarrhea Y N Leukemia Y N Spinas Bifdia Y N Heart Murmur Y N Heart Murmur Y N Heart Murmur Y N Pain In Jaw Jolnts Y N Welling Spelisr/Dizcinses Y N Heart Murmur Y N Pain In Jaw Jolnts Y N Welling Spelisr/Dizcinses Y N Heart Murmur Y N Pain In Jaw Jolnts Y N Welling Ol Limbs Y N Welling Spelisr/Dizcinses Y N Heart Murmur Y N Pain In Jaw Jolnts Y N Welling Jamese Y N Heart Murmur Y N Pain In Jaw Jolnts Y N Welling Jamese Y N Heart Murmur Y N Pain In Jaw Jolnts Y N Welling Jamese Y N Heart Murmur Y N Pain In Jaw Jolnts Y N Welling Jamese Y N Heart Murmur Y N Pain In Jaw Jolnts Y N Welling Jamese Y N Heart Murmur Y N Pain In Jaw Jolnts Y N Welling Jamese Y N Welling Jamese Y N Heart Murmur Y N Pain In Jaw Jolnts Y N Welling Jamese Y N Weli	Do you take, or have you t	aken, Ph	en-Fen or Redux?	Y N	If YES:				
Do you use controlled substances? WOMEN: Are you Pregnant/Trying to get pregnant? Nursing? Taking Oral Contraceptives? Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Aspirin Penicillin Codeine Acrylic Acrylic Sulfia Drugs Local Anesthetics Dental Local A	Have you ever taken Fosa medications containing bis Are you on a special diet?	max, Bon phosphor	niva, Actonel or any other nates?						
Do you use controlled substances? WOMEN: Are you Pregnant/Trying to get pregnant? Nursing? Taking Oral Contraceptives? Are you allergic to any of the following? Aspirin Penicillin Codeine Aspirin Metal Latex Sulfia Drugs Local Anesthetics Debrata HISTORY Do you have, or have you had, any of the following? NUSHIV Positive Y N Cortizone Medicine Y N Hemophilia Y N Readiation Treatments Y N Naphalaxis Y N Naphalaxis Y N Drug Addiction Y N Hepatitis B or C Y N Renal Dialysis Y N Anemia Y N Easily Winded Y N Hephalis B or C Y N Renal Dialysis Y N Anemia Y N Easily Winded Y N High Blood Pressure Y N Nathritis/Gout Y N High Cholesterol Y N Scalet Fever Y N Artificial Joint Y N Excessive Bleeding Y N High Cholesterol Y N Sickle Cell Disease Y N Reanting Problems Y N Reanting Problems Y N Reanting Problems Y N Reanting Problems Y N Gental Headaches Y N Reanting Problems Y N Gental Headaches Y N Reanting Problems Y N Gental Headaches Y N Reanting Problems Y N Gental Heart Marker Y N High Cholesterol Y N Sickle Cell Disease Y N N Reathing Problems Y N Gental Heart Marker Y N Reathring Problems Y N Gental Heart Marker Y N Gental Heart Marker Y N High Cholesterol Y N High Cholesterol Y N Sickle Cell Disease Y N N High Rodesterol Y N Sickle Cell Disease Y N High Rodesterol Y N High Cholesterol Y N Sickle Cell Di	Do you use tobacco?			ΥN	If YES:				
WOMEN: Are you Pregnant/Trying to get pregnant?	,	stances?		ΥN	If YES:				
Pregnant/Trying to get pregnant? Nursing? Taking Oral Contraceptives?	,								
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Other? If YES: DENTAL HISTORY Do you have, or have you had, any of the following? AlzS/HIV Positive Y N Cortizone Medicine Y N Hemophilia Y N Recent Weight Loss Y N Alpahalaxis Y N Diabetes Y N Hepatitis A Y N Recent Weight Loss Y N Anaphalaxis Y N Drug Addiction Y N Hepatitis B or C Y N Renal Dialysis Y N Anemia Y N Easily Winded Y N Herpes Y N Rheumatic Fever Y N Angina Y N Epilepsy/Seizures Y N High Blood Pressure Y N Rheumatic Fever Y N Arthritis/Gout Y N Epilepsy/Seizures Y N High Cholesterol Y N Scarlet Fever Y N Artificial Heart Valve Y N Excessive Bleeding Y N Hives or Rash Y N Shingles Y N Asthma Y N Excessive Thirst Y N Hypoglycemia Y N Sinus Trouble Y N Asthma Y N Fainting Spells/Dizziness Y N High Cholesterol Y N Sinus Trouble Y N Frequent Diarrhea Y N Leukemia Y N Sinus Trouble Y N Sinus Trouble Y N Sinus Easily Y N Genital Herpes Y N Leukemia Y N Stomach/Intestinal Disease Y N Brautise Easily Y N Genital Herpes Y N Low Blood Pressure Y N Swelling of Limbs Y N Chemotherapy Y N Heart Murmur Y N Date Pain Heart Alvalve Problems Y N Tonsilitis Y N Heart Murmur Y N Heart Murmur Y N Pain In Jaw Joints Y N Tuberculosis Y N Congenital Heart Disease Y N Heart Murmur Y N Pain In Jaw Joints Y N Tuberculosis Y N Congenital Heart Disease Y N Heart Murmur Y N Pain In Jaw Joints Y N Tuberculosis Y N Congenital Heart Disease Y N Heart Murmur Y N Pain In Jaw Joints Y N Ulcers Y N Heart Pacemaker Y N Parathyroid Disease Y N V Heart Provide/Disease Y N Parathyroid Disease Y N V Heart Provide/Disease Y N Parathyroid Disease Y N V Heart Provides Y N Heart Provide Provides Y N Parathyroid Disease Y N V N Heart Provides Y N Parathyroid Disease Y N V N Heart Provides Y N Parathyroid Disease Y N V N Heart Provides Y N Parathyroid Disease Y N V N Heart Provides Y N Parathyroid Disease Y N V N Heart Provides Y N Parathyroid Disease Y N V N N N N N N N N N N N N N N N N N	Aspirin	L	Penicillin	L	Code	ne		,	
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FINANCIAL POLICY AND DENTAL INSURANCE

Dear Patient:

Thank you for choosing our office for your dental needs. We always strive to maintain quality dentistry with compassion in a comfortable and friendly atmosphere. We hope that you and your family will feel welcome in our dental family. We would like to acquaint you with our policies regarding dental insurance, financial arrangements and schedule changes.

We do not want finances to be an issue for our patients. We want you to feel comfortable with us, and that includes feeling satisfied with your financial arrangement regarding your operative and restorative dentistry. We encourage you to enter into a financial arrangement that is comfortable for you. For your ease and convenience, we offer several types of financial arrangements for out-of-pocket costs of \$300 or more (anything less than \$300 is due at time of service).

- We offer comfortable financing through **Care Credit** which offers up to 12 months **NO INTEREST** financing as well as long term plans with low interest rates. You must qualify to use any of the plans offered by **Care Credit**. Please do not hesitate to ask us about this option. We will conveniently qualify you right here in the office today.
- For major cases your financial obligation may be paid (with or without benefit of insurance) by choosing one of the following: ½ of the treatment fee is expected at the initial preparation appointment with the balance due at the delivery of the case or 1/3 due when the appointment is scheduled, 1/3 due at the initial preparation appointment and the final 1/3 due at the delivery of the case.
- We accept Visa, MasterCard, Discover and American Express, checks and cash.
- Senior citizens (age 65+) will receive a 10% courtesy after insurance has paid. If no insurance is involved the courtesy will be immediate.

Dental Insurance

- Dental Insurance **As a courtesy to you,** if you have dental insurance we will complete your insurance form with all the necessary information and submit it to the primary insurance company. Your co-payment will be estimated and is due at the time of service unless other arrangements are made with this office. **Unless we are a participating provider with the carrier, any secondary coverage is the responsibility of the insured.**
- If your insurance company has not made a payment within 60 days of billing, the balance will become your responsibility. You will be billed for any balance due. Insurance coverage is a contractual agreement between the insurance company and you and/ or your employer. We have no control over this relationship. **Again, unless we are a participating provider with the carrier, any secondary coverage is the responsibility of the insured.**

All patients with an outstanding balance will receive a statement each month. We reserve the right to charge any outstanding balance over 25 days a finance charge of 1.5 (18% APR).

Please understand that we take the time that we have scheduled for you and your dental health very seriously and we hope for the same consideration. As a courtesy, we attempt to remind our patients of their appointment by phone call and ask for a confirmation response. However, we hope that our patients do not rely solely on our courtesy reminders. <u>Therefore</u>, we reserve the right to charge for appointments broken without the proper 24 hours or 1 business day's notice.

SIGNIFICANT EXPOSURE - Section 32.1-45,1(A) and (B), Code of Va. (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitis virus is considered to have been given by the patient and /or healthcare worker thereby granting the Hospital the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of the local hospital.

I authorize and release information and payment of my dental benefits to the dentist. I have read and understand fully my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees at 33.3% court costs and any other charges incurred to collect this account. Additionally, by signing this form I hereby authorize Loudoun Dental Associates to process Credit Card transactions initiated by me either by mail or phone and authorize my credit institution to pay.

Signature	of	Patient,	Parent	or	Guardian



24565 DULLES LANDING DR., STE 190 DULLES, VA 20166

> PH: 703.542.7600 FAX: 703.542.7792

team@loudoundentalassociates.com LINDSAY HAYLEY, PRIVACY OFFICER

HIPAA NOTICE OF PRIVACY PRACTICES

Parent or Guardian of Minor Patient Guardian or Conservator or Incompetent Patient ACKNOWLEDGMENT OF PRIVACY NOTICE Loudoun Dental Associates will use and disclose your personal health information to treat you, to receive paym care we provide, and for other health care operations. Health care operations generally include those activities we p to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you understand our policies in regard to protected health information. The terms of this notice may change with time, a will post the current notice at our facility and have copies available for distribution. I acknowledge I have received, re understand the NOTICE OF PRIVACY PRACTICES. I also give Loudoun Dental Associates permission to speak to the following people (if regarding my health information: Signature of Patient, Parent or Guardian Patient's Printed Name Date			
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