LOUDOUN DENTAL ASSOCIATES

24565 DULLES LANDING DR., STE 190
DULLES, VA 20166
PH: 703.542.7600
FAX: 703.542.7792
team@loudoundentalassociates.com

NEW PATIENT REGISTRATION

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTH DATE

ADDRESS

CITY STATE ZIP

PHONE (H) (C)	EMAIL
SOCIAL SECURITY NUMBER	DRIVERS LICENSE NUMBER

SEX: ☐ M ☐ F IS PATIENT POLICY HOLDER? ☐ Y ☐ N

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE

RESPONSIBLE PARTY INFORMATION (IF SOMEONE OTHER THAN PATIENT)

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTH DATE

ADDRESS

CITY STATE ZIP

PHONE (H) (C)	EMAIL
SOCIAL SECURITY NUMBER	DRIVERS LICENSE NUMBER

SEX: ☐ M ☐ F RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ CHILD ☐ OTHER

PRIMARY INSURANCE INFORMATION

EMPLOYER	EMPLOYER ADDRESS
DENTAL INSURANCE CO.	
GROUP NUMBER	MEMBER ID

SECONDARY INSURANCE INFORMATION

EMPLOYER	EMPLOYER ADDRESS
DENTAL INSURANCE CO.	
GROUP NUMBER	MEMBER ID

NEW PATIENT REGISTRATION

PATIENT NAME	BIRTH DATE	CREATION DATE

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication you may be taking, can impact your dental health.

MEDICAL HISTORY

Are you under a physician's care now?	Y N	If YES:	
Have you ever been hospitalized or had a major surgery?	Y N	If YES:	
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:	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Y N	If YES:	
Are you on a special diet?	Y N	If YES:	
Do you use 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?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfia Drugs ☐ Local Anesthetics

☐ Other? If YES:

DENTAL HISTORY

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Y N	Cortizone Medicine	Y N	Hemophilia	Y N	Radiation Treatments	Y N
Alzheimer's Disease	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	Emphysema	Y N	High Blood Pressure	Y N	Rheumatism	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
Artificial Joint	Y N	Excessive Thirst	Y N	Hypoglycemia	Y N	Sickle Cell Disease	Y N
Asthma	Y N	Fainting Spells/Dizziness	Y N	Irregular Heartbeat	Y N	Sinus Trouble	Y N
Blood Disease	Y N	Frequent Cough	Y N	Kidney Problems	Y N	Spina Bifida	Y N
Blood Transfusion	Y N	Frequent Diarrhea	Y N	Leukemia	Y N	Stomach/Intestinal Disease	Y N
Breathing Problems	Y N	Frequent Headaches	Y N	Liver Disease	Y N	Stroke	Y N
Bruise Easily	Y N	Genital Herpes	Y N	Low Blood Pressure	Y N	Swelling of Limbs	Y N
Cancer	Y N	Glaucoma	Y N	Lung Disease	Y N	Thyroid Disease	Y N
Chemotherapy	Y N	Hay Fever	Y N	Mitral Valve Prolaps	Y N	Tonsilitis	Y N
Chest Pains	Y N	Heart Attack/Failure	Y N	Osteoporosis	Y N	Tuberculosis	Y N
Cold Sores/Fever Blisters	Y N	Heart Murmur	Y N	Pain in Jaw Joints	Y N	Tumors or Growths	Y N
Congenital Heart Disease	Y N	Heart Pacemaker	Y N	Parathyroid Disease	Y N	Ulcers	Y N
Convulsions	Y N	Heart Trouble/Disease	Y N	Psychiatric Care	Y N	Venereal Disease	Y N
						Yellow Jaundice	Y N

Have you ever had any serious illness not listed above? Y N If YES:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian DATE

LOUDOUN DENTAL
ASSOCIATES

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. *Therefore, 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 _____ DATE _____

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LINDSAY HAYLEY, PRIVACY OFFICER

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

I hereby acknowledge that I have read and received a copy of the attached dental practice's **HIPPA NOTICE OF PRIVACY PRACTICES OF LOUDOUN DENTAL ASSOCIATES.**

Signature of Patient, Parent or Guardian _____ Printed Name _____ Date _____

If not signed by the patient, please indicate relationship:

☐ Parent or Guardian of Minor Patient ☐ Guardian or Conservator or Incompetent Patient

Name of Patient _____

ACKNOWLEDGMENT OF PRIVACY NOTICE

Loudoun Dental Associates will use and disclose your personal health information to treat you, to receive payment for care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regard to protected health information. The terms of this notice may change with time, and we will post the current notice at our facility and have copies available for distribution. I acknowledge I have received, read and understand the **NOTICE OF PRIVACY PRACTICES.**

I also give **Loudoun Dental Associates** permission to speak to the following people (if any) regarding my health information:

_____ _____

_____ _____

Signature of Patient, Parent or Guardian _____ Patient's Printed Name _____ Date _____

For Office Use Only:

Signed form received by:

Acknowledgment refused:

Efforts to obtain:

Reason for refusal: