Nokesville Family Dentistry

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Lauren M. Simon, DDS, PLLC

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Name: ____ Prefers to be called by: ____________________________

Last First MI

Address: ____

City State Zip

Home Phone: ____________________________ Work Phone: ______________________________ Cell: ____________________________

Email: ____ Marital Status (Circle One): Single Married Divorced Widowed

Social Security Number: ___________________________________ Birthdate: ____________________________ Gender: Male Female

Who may we thank for referring you? Family/Friend_______________________Internet____Sign____Other(specify)____________________

Name

Emergency Contact

Name: ___________________________________Relationship:____________________________Phone Number:_________________________

Name: ___________________________________ Relationship: ____________________________Phone Number:__________________________

Financial Party Information

Name: ____ Relationship to Patient: _________________________

Last First MI

Address: ____

City State Zip

Phone Number: _____________________________________ Social Security Number: ____

Insurance Information – Please present dental insurance card prior to treatment.

Insurance Company: ____ Employer: ____

Policy Holder's Name: ____ Policy Holder's Birthdate: __________________________________

Policy Number: ____ Group Number: _____________________________________

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand deposits may be requested to reserve future appointments, unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be rendered to my account. If account is unpaid in 90 days then I understand that collections processing may occur and I may be charged 40% processing fee of the past due balance.
5. I acknowledge receipt of Notice of Privacy Practices.
6. I ____, hereby give my consent to Lauren M. Simon, DDS, to use my dental photographs, video, slides, or any other image, with or without my name, for educational purposes and in the use of promoting aesthetic dentistry.

____ ____________________________________

Patient/Parent Signature Date

PATIENT MEDICAL HISTORY

____ ____

Patient Name **Date**

Primary Care Physician: ____________________ Office Phone: ___________________ Date of last exam: _______________

Please check YES or NO for each question:	**YES**	**NO**
Are you under medical treatment now?		
If yes, describe in comments below.		
Have you ever been hospitalized for any surgical operation or serious illness?		
Are you taking any medication(s) including non-prescription medicine? If yes, describe in comments below.		
Do you use tobacco? If yes, what type:		
Do you use alcohol?		
Do you use recreational drugs?		
Have you ever needed to take antibiotic before a dental appointment?		

Are you allergic to:	**YES**	**NO**
Local anesthetics?		
Penicillin ?		
Sulfa drugs?		
Aspirin?		
Latex		
Other:		
Other:		
FOR WOMEN ONLY:		
Are you pregnant?		
Are you nursing?		
Are you taking birth control pills?		

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

	YES	**NO**
AIDS or HIV		
Anemia		
Angina		
Arthritis		
Asthma		
Cancer		
Cardiac pacemaker		
Chest pains		
Diabetes		
Emphysema		
Epilepsy/ convulsions		
Fainting/ seizures		
Glaucoma		

	YES	**NO**
Hay fever/ allergies		
Heart attack		
Heart disease		
Heart murmur		
Heart surgery		
Hepatitis/ jaundice		
High blood pressure		
Joint replacement/ implant		
Kidney disease		
Leukemia		
Liver disease		
Low blood pressure		
Mitral valve prolapse		

	YES	**NO**
Radiation Therapy		
Respiratory problems		
Rheumatic fever		
Sexually transmitted disease		
Sinus trouble		
Snoring/Sleep Apnea		
Stroke		
Stomach troubles/ ulcers		
Swollen ankles		
Thyroid problem		
Tuberculosis		
Valve repair/ artificial valve		
Other:		

If you could change your smile, what would you do? ____

On a scale of 1-10 (10 is highest) How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health: 1 2 3 4 5 6 7 8 9 10 Why? _______________________

What is the most important thing to you about your future smile and dental health? _________________________________

Why did you leave your previous dentist? ____

Medications: ____

Comments: ____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health.

Signature: ____ Reviewed by: ____

Patient, Parent, or Guardian

IMPORTANT INFORMATION

APPOINTMENTS & PAYMENTS

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important health service. When we make an appointment for you, we are promising to give our full attention to provide the finest dental care possible during the reserved time. It is a bond of trust between you and our team. In return, we expect the patient to be present, punctual, and prepared for their appointment. Because we plan for your services several days before your actual reserved appointment, **we require a minimum of 48-hours advanced notice (72-hours advanced notice for appointments longer than 2 hours) if you need to reschedule your appointment.**

- If a patient fails to show for a reserved appointment or reschedules their appointment within the time stated above, a broken appointment fee ranging $25-$100 will be applied to their account.

- We request that payment arrangements be made prior to starting your treatment. We will collect 50% of your portion at the time of reserving your future treatment appointment. The remaining portion will be collected on the date of your reserved appointment.

We are sensitive to the fact that people have different needs in fulfilling their financial obligations. There are times when monthly payment options will be available. If you are interested in hearing more about monthly payment options, please do not hesitate to ask ahead of time. We would be happy to assist you with the application process.

LATE PAYMENTS

You are responsible for paying your bill. Payment of your bill is due within 30 days of the billing date. If you do not pay your bill within 30 days of the billing date, a $15 late charge will be added to your account. If you have questions about your bill, please call our office and we would be happy to assist you.

NON-SUFFICIENT FUNDS/RETURNED CHECKS

A check is considered non-sufficient funds/returned when the check has been rejected from the bank for insufficient funds. If we receive a returned check, a NSF fee of $30 will be charged to your account and an alternative payment method must be used. The account will be flagged for 12 months and if a second check is returned for non-sufficient funds, we will no longer be able to accept checks as a form of payment towards your account.

I have read and understand my responsibilities as a patient and/or guarantor.

____

Print Patient Name **Print Guarantor Name**

____

Patient/Guarantor Signature **Date**

NOKESVILLE FAMILY DENTISTRY
LAUREN M. SIMON, DDS, PLLC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

- Federal law says that we cannot share our health information without your permission except in certain situations. If you sign this form, you are giving us permission to share your health information that we have with the person you indicate below.
- This authorization is voluntary.
- Your treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether you sign this authorization
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I, ___________________________________, give permission to **Lauren M. Simon, DDS, PLLC** to share

the following protected health information, and/or disclose the following protected health information with:

___No One

Name________________________________Relationship__________________ Phone # ________________________

Name________________________________Relationship__________________ Phone # ________________________

Name________________________________Relationship__________________ Phone # ________________________

Information to be disclosed (check all that apply):

Medical Records	_____	Test Results	_____
Treatment Records	_____	Treatment Recommendations	_____
Diagnostic Records	_____	Accounting	_____
Demographic Information	_____	Appointment Dates/Times	_____

Other: ____

This authorization expires on _____________________

Patient Signature ____

Print Patient Name ____

Date ____

Right to revoke: If you decide you do not want us to share your health information any longer; you have the right to revoke this authorization, in writing, at any time.

P.O. Box 68, 12908 Fitzwater Drive, Nokesville, VA 20181 (703)594-2151

NOKESVILLE FAMILY DENTISTRY

LAUREN M. SIMON, DDS, PLLC

Patients with Out of Network Dental Insurance:

- We will assist you to maximize your benefits.
- **Please carefully read your policy and be aware of all aspects of your insurance coverage. We recommend going online to your insurance company or calling and requesting a faxed copy of your benefits.**
- Fees are determined by the level of care, skill, and judgment a procedure requires and are the same regardless of whether you are insured or not.
- Insurance coverage varies widely. This coverage is usually based on the level of policy purchased by your employer or group. **Please remember your employer and insurance company dictate your coverage, not our office.**
- **We can only ESTIMATE what your insurance coverage may be**. All claims are submitted to your insurance company. **We are not in-network with your dental insurance plan.**
- Please select one of the following ways for us to submit claims to your dental plan on your behalf:

1- Pay in full for all visits and have insurance reimburse you directly. We will be happy to submit your claims for you.
2- If insurance allows payment directly to our office, pay your estimated portion and keep **a credit card authorization on file to be used for any balance remaining after insurance processes the claim**. Your estimated copay will be collected at the time your appointment is reserved. Any remaining balances from insurance will be automatically charged to your credit card.

I select: Option 1 ________ Option 2 _______

We are available to answer any questions you may have.

Yours in Health, *Dr. Lauren M. Simon*

I ___________________________________, have read and understood the information above,

X____ Date______________

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NOKESVILLE FAMILY DENTISTRY
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Patients with Participating PPO Dental Insurance:
Aetna PPO - Delta Premier – Cigna DPPO

Other select plans that may fall within the Aetna PPO & Cigna DPPO networks;
GEHA, Assurant, Core Source, Guardian and others.

- ❖ The above plans have various networks. It is possible that your plan does not include the network that our office is participating in. We encourage you to contact your insurance company to confirm your current network and participation status. Benefits may or may not change if using out of network benefits however, some Delta plans will only reimburse the policy holder if using your out of network benefits. Patients with Delta PPO will only be considered in-network if their benefits include the Premier option.

- ❖ We will do our best to maximize your benefits however we will not allow your benefits to dictate treatment recommendations.

- ❖ **Please carefully read your policy and be aware of all aspects of your insurance coverage. We recommend going online to your insurance company or calling and requesting a faxed copy of your benefits.**

- ❖ Fees are determined by the level of care, skill, and judgment a procedure requires and are the same regardless of whether you are insured or not.

- ❖ Insurance coverage varies widely. This coverage is usually based on the level of policy purchased by your employer or group. **Please remember your employer and insurance company dictate your coverage, not our office.**

- ❖ **We can only estimate what your insurance coverage may be**. All claims are submitted to your insurance company. You are responsible for any balance that your insurance company does not pay.

- ❖ We will do our best to provide you with an estimate of coverage for services. This is only an estimate. Many plans have “non-covered” services that are not disclosed clearly in your policy. If your plan denies a service as being “non-covered” or “re-codes” or “down-grades” a service billed to provide an “alternate benefit” then you are responsible for the full office fee instead of the participating adjusted fee pursuant to Virginia State Law.

- ❖ Payment of your estimated portion will be due at each appointment and sometimes prior to the appointment date in form of a deposit.

I ___________________________________, have read and understood the information above,

X____ Date_____________