Nokesville Family Dentistry

PATIENT REGISTRATION

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. 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 understand deposits will be requested to reserve future appointments, unless other arrangements have been made. I agree to provide 3 business days' notice if I am unable to keep an appointment and understand that I will be charged a broken appointment fee if the required notice is not provided.**
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

APPOINTMENTS & PAYMENTS

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. In return, we expect you, the patient, to be present, punctual, and prepared for your appointment.

1. **Appointments are reserved specifically for you.** We ask that you provide 3 business days' notice if you are unable to keep an appointment. You will be charged a broken appointment fee if the required notice is not provided. Broken appointment fees vary and are based on length of appointment.

2. **Our office is open on many Federal Government Holidays** in order to offer our patients appointment options without missing work. As you can imagine, these days fill up months in advance. Because of the high demand of patients wanting to be seen on the holiday, we require a $75 reservation fee OR your appointment to be pre-paid in full. In addition, we ask that you confirm your holiday appointment 7 days in advance. If for some reason you are unable to keep your reserved appointment, the reservation fee will be put towards your broken appointment fee.

3. **We request that payment arrangements be made prior to starting your treatment.** We will collect a deposit of your future treatment appointment at the time of reserving your 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.

PAYMENTS & ESTIMATES FOR TREATMENT

We will do our best to provide you with an estimate of your dental coverage for services. This is only an estimate. Many plans have exclusions and/or non-covered services that are not disclosed clearly in your policy. If your plan denies a service as being non-covered or recodes/downgrades a service billed to provide an alternate benefit, then you are responsible for the difference.

You are ultimately responsible for any balance on your account. 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

If your bank rejects/returns your check payment for insufficient funds, you will be charged the bank fee of $30.

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_____

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