BETHESDA DENTAL GROUP

PLEASE COMPLETE ALLINFORMATION THAT APPLIES TO YOU - THANK YOU

PATIENT LAST NAME: _____FIRST:_____INITIAL

How did you hear about us?_____

Whom may we thank for your referral? _____

Date of Birth: _____Single:_____Married: _____Divorced:_____ Male: _____Female:_____

Telephone (Home)_____(Work)_____(Mobile)_____

Address_____

City_____State_____Zip_____

Email_____

Employer_____

Occupation_____

Soc. Sec. No._____

DentalInsurance Co._____

Group #_____

Is patient covered by another dental insurance? ____Yes____No

Insurance Co._____

Husband, Wife, or Other Responsible Party (If Not Self)

Last Name_____First_____Initial_____

Address_____

DOB_____City_____State_____Zip_____

Telephone (Home)_____(Work)_____(Mobile)_____

Email_____

Employer_____Occupation_____

Soc. Sec. No._____

Emergency Contact

Name: _____Phone:_____

Relationship to patient: _____

DentalHealth History

Please check if you have/had:

Bad breath ☐ Gums swollen, tender, or bleeding ☐

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Blisters on lips or mouth	☐	Growths or sore spots in mouth	☐
Burning sensation on tongue	☐	Head, neck, or jaw pain or aches	☐
Chew on one side of mouth	☐	Lip or cheek biting	☐
Cigarette, pipe, or cigar smoking	☐	Loose teeth or broken fillings	☐
Smokeless tobacco	☐	Mouth breathing	☐
Dry mouth	☐	Orthodontic treatment	☐
Food collection between teeth	☐	Nitrous Oxide	☐
Clench teeth	☐	Periodontal treatment	☐
Grind teeth	☐	Sensitivity to pressure or irritants (Cold, heat, sweets)	☐

Are you satisfied with your smile?___Yes___No

If no, please explain_____

How often do you floss? _____

How often do you brush? _____

Have you ever had an allergic reactions to Novocaine, local or general anesthetics?

If yes, please explain: _____

Have you had trouble from previous dental care?

If yes, please explain: _____

Reason for today's visit: _____Former dentist: _____

Date of last dental visit: _____

MedicalHealth History

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Physician's name: _____Date of last visit: _____

Physician's address: _____

Have you ever had a blood transfusion? ___Yes ___No If yes, please describe: _____

Have you had any serious illnesses or operations? ___Yes ___Noif yes, please give approximate date_____

Birth Control Pills? __Yes __NoPregnant? __Yes __No If Yes Due Date? _____ Nursing? _____

Please check if you have/had:

Allergies, hay fever, sinusitis	☐	Anemia	☐
Arthritis, Rheumatism	☐	Artificial Heart Valves	☐
Artificial Joints	☐	Asthma	☐
Asthma: Required Hospitalization	☐	Asthma: Used Steroids	☐
Bleeding abnormally with operation/surgery	☐	Blood Disease, Clotting Disorders	☐
Cancer	☐	Chemical Dependency	☐
Chemotherapy	☐	Circulatory Problems	☐
Cortisone Treatments	☐	Cough, persistent or bloody	☐
Diabetes	☐	Emphysema	☐
Epilepsy	☐	Fainting	☐
Glaucoma	☐	Headaches	☐
Heart Murmur	☐	Heart Problems	☐
Hepatitis, If yes type: _____	☐	High Blood Pressure	☐
Herpes	☐	Jaundice	☐
Any Immune Deficiency (incl. HIV/AIDS)	☐	Low Blood Pressure	☐
Kidney Disease	☐	Organ Transplant	☐
Mitral Valve Prolapse	☐	Osteopenia	☐
Osteoporosis	☐	Pacemaker	☐
Radiation Treatments	☐	Respiratory Disease	☐
Rheumatic Fever	☐	Scarlet Fever	☐
Shortness of Breath	☐	Sinus Trouble	☐
Sickle Cell Anemia	☐	Skin Rash	☐
Stroke	☐	Swelling of Feet/Ankles	☐
Thyroid Problems	☐	Tonsillitis	☐
Tuberculosis	☐	Tumor or Growth on Head/Neck	☐
Ulcer	☐	Venereal Disease	☐
Weight Loss, Unexplained	☐	Do you consume alcoholic beverages?	☐
Do you wear contact lenses?	☐	Are you allergic/sensitive to Latex?	☐
Allergic to penicillin, Aspirin or Other Drugs?	☐	Are you currently taking any Medications?	
If yes, please list:		If yes, please specify:	
_____		_____	
_____		_____	

Patient/Guardian Signature: _____Date:_____

Reviewed By: _____Date:_____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize any information concerning myself (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits, I hereby authorize payment of insurance benefits directly to the dentist or dental group, orwise payableto me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer. I also understand that I will be charged a $25.00 fee for any appointment cancelled less than 24 hours before the scheduled date. I attest to the accuracy of the information on this page.

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Signature: _____Date:_____

HIPAA PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICESSIGNATURE PAGE

I have read and received a copy of the HIPAA patient acknowledgement information and I understand that my personal health information will be protected and shared with only those I authorized with a signed consent form.

I also have the right to review Strasburg Family Dentistry's privacy notice, to request restrictions and revoke consent, in writing, after I have reviewed this notice.

I further understand that my information could be used to obtain payment from third-party payers for my health care services.

It may also be used under normal health care operations, such as quality assessment and improvement activities.

I have been informed of Strasburg Family Dentistry's privacy practices and have received a more complete copy containing information about my personal health information (PHI). I understand that Strasburg Family Dentistry has the right to change their practices and that I may contact the office to receive a current copy of their privacy practices.

_____
Print Patient / Parent / Guardian's Name

_____
Signature

_____
Witness Signature

_____
Date

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HIPAA PATIENT ACKNOWLEDGEMENTOF PRIVACY PRACTICES FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure the personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient’s consent for uses and disclosures of health information about the patient, to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, In order to provide health care that is in your best interest.

We also want you to know that we support our full access to your personal dental records as provided by the Virginia Code. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuseto disclose your Personal Health Information (PHI). If you choose to give consent in the document, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken, which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer at 540-465-3399