SMILES FAMILY DENTISTRY

We are pleased to welcome you to our practice. Please take a few minutes to fill out the form. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Preferred Name: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Sex: ○ Male ○ Female

Birth Date: _____ Age: _____ Soc. Sec: _____

Email: _____ ○ I would like to receive correspondence via email

Employer: _____ Occupation: _____

Spouse: _____

Children's Names: _____

Is there anyone we may thank for referring you to our offices? _____

Primary Dental Insurance Information

Name of Insured: _____ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec. _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____ Ins. Phone#: _____

Ins. Co. Address: _____

Group #: _____ ID #: _____

Payment Options

To help keep the cost of dentistry down and to continue to provide quality care to our valued patients, we now expect payment in full on your first visit. Subsequent visit balances not covered by your insurance can be paid using the following options:

Please (✓) below the option(s) most convenient for you to pay on your account balance.

- ○ Cash
- ○ Check
- ○ Visa, MC, Amex, or Discover
- ○ Easy monthly payment program (see insurance coordinator for application)

_____ _____

Signature of Responsible Party Date

Name _____ Date of Birth _____

SMILES FAMILY DENTISTRY

Medical History

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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes Please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes Please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes Please explain: _____

Do you use tobacco? ☐ Yes _____

Have you taken Fosamax, Aredia, Actonel, Boniva or Zometa for osteoporosis or cancer therapy? ☐ 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 ☐ Local Anesthetics ☐ Jewelry

☐ Other If yes, please explain: _____

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

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Breathing Problem
- ☐ Cancer
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Convulsions
- ☐ Diabetes
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells/Dizziness
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ MItral Valve Prolapse
- ☐ Osteoporosis
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Rheumatic Fever
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes Please explain: _____

List any medications you are taking (including non prescription medications): _____

Dental History

Do your gums bleed while brushing or flossing? ☐ Yes ☐ No

Are your teeth sensitive to sweets or temperature? ☐ Yes ☐ No

Have you experienced pain or difficulty opening/closing your jaw? ☐ Yes ☐ No

Are you happy with your smile and the appearance of your teeth? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

When was your last dental visit? _____

Authorization, Consent and Release

Consent: I give my consent to the doctor and staff to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Signature of patients (or parent/guardian of minor)

D-Smiles Family Dentistry
8082 Crescent Park Drive
Gainesville, VA 20155
571-261-9038

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Kim-Ngan Do, D.M.D. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

D-Smiles Family Dentistry reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURES AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY _____YES_____NO

SPOUSE ONLY _____YES_____NO

OTHER (Please Specify): _____YES_____NO

_____ _____
Name of Patient or Personal Representative Signature of Personal or Personal Representative

_____ _____
Date Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE
Record of Acknowledgement not obtained

PROVIDED PRIOR TO TREATMENT? _____YES _____NO

DATE PROVIDED_____

REASON FOR DENIAL: _____NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.

_____WANTED TO CONSULT WITH ANOTHER PERSON, BEFOE SIGNING.

_____UNABLE TO SIGN.

_____REASON NOT GIVEN.

_____OTHER (EXPLAIN):

D-Smiles Family Dentistry
8082 Crescent Park Drive
Gainesville, VA 20155

Financial/Insurance Policy Acknowledgement

The following information is to inform you of our financial policy. If, any time, you have a question regarding this policy, please do not hesitate to ask any member of our business team. We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, MasterCard, Discover and American Express. We also partnered with a third party company to offer the flexibility of deferred interest and extended payment options. Check policy: if your check is returned for any reason, there is a processing fee of $25.

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered. We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment; however, any appointment missed may be subject to a missed appointment of $50. Should you find it necessary to reschedule an appointment, please provide us with a notice of 24 hours before the appointment time to avoid being charged a missed appointment fees.

Important Facts About Your Dental Insurance

As a courtesy to our patients with dental insurance benefits, we will submit your claim by mail, via fax or electronically to a HIPPA complaint clearing house and provide any necessary information to assist you in receiving your dental benefits. We are a participating doctor in many PPO networks. As a participating dentist, your fees are set by your insurance company lower than UCR (usual customary rate) and our contract requires that nay applicable deductibles and estimated patient portion be collected in full. There shall be no further discount from the set fees. A discount sounds great; however, failure to comply, could result both you more money and the doctor breaching his contract agreement, a serious violation. Please contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise our doctor's diagnosis or affect your choice of treatment. It is your responsibility to understand the type of dental insurance you have and the benefits our selected by you and/or your employer. You (not the insurance) are responsible for the fees of services rendered. If applicable, I authorize Dr. Kim-Ngan Do to file all claims for service rendered to me and I have provided all my insurance information correct. I further authorize Dr. Kim-Ngan Do to release any information, including medical information for his or any related claims to my insurance company (ies) or reimbursing agency in order to determine benefits to which I am entitled. I am informed that if I request to restrict disclosure of information, I can pay out-of-pocket for the treatment and any treatment shall not be submitted to my insurance company (ies) as long as I inform in writing to Dr. Kim-Ngan Do and staff.

I consent to necessary treatment, I authorize the release of any medical records to referring and/or family physicians, and to my insurance (if applicable). A fee of $25 dollars for all records transfer. I understand that payment for services is due at time of service and any unpaid balance will be charged interest at the rate of 24% (per annum) and that I will be responsible for attorney fees in the amount of 35% for any account turned over to an attorney for collection.

I have read and fully understand the above consent for treatment financial responsibility, and release of medical information. I understand that the status of this authorization shall remain in effect as long as I am a patient of Dr. Kim-Ngan Do. If I wish to change the status of this form I must do so in writing.

Signature_____, Please Print: _____

If patient is under 18,
I understand is a parent/guardian of the patient and executed this form on his/her behalf. In my absence my child's appointment at any time, I consent that necessary treatment including x-rays for my child. I am financially responsible for him/her unpaid balance.

Name of Patient _____, Relationship: _____

Signature: _____, Please Print and Date: _____