DATE _____

PATIENT NAME _____ DATE OF BIRTH _____
LAST FIRST MIDDLE (MAIDEN)

ADDRESS _____

_____

HOME PHONE # _____ WORK PHONE # _____

SOCIAL SECURITY # _____ CELL PHONE # _____

OCCUPATION/EMPLOYER _____

ADDRESS _____

IN CASE OF EMERGENCY CONTACT _____

BEST NUMBER TO CONTACT _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME _____ DATE OF BIRTH _____
LAST FIRST MIDDLE

ADDRESS _____

_____

HOME PHONE # _____ CELL PHONE # _____

SOCIAL SECURITY # _____

DENTAL INSURANCE INFORMATION

POLICY HOLDERS NAME _____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT: _____ POLICY HOLDERS DATE OF BIRTH _____

INSURANCE COMPANY'S NAME _____

PHONE # _____

ADDRESS _____

I.D. NUMBER _____

GROUP POLICY NUMBER _____

EMPLOYER _____

over please

DENTAL HISTORY

DATE OF YOUR LAST DENTAL EXAM _____

DENTIST'S NAME _____

WAS TREATMENT RECOMMENDED? _____ WAS TREATMENT COMPLETED? _____

DO YOU HAVE PROBLEMS WITH YOUR TEETH? _____

If yes, what kind of problems.

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO	
☐	☐	BLEEDING GUMS	☐	☐	FILLINGS THAT FEEL ROUGH
☐	☐	LOOSE TEETH	☐	☐	USE "NOVOCAINE"
		SENSITIVITY TO:	☐	☐	USE NITROUS OXIDE (Laughing Gas)
☐	☐	a. sweet	☐	☐	HAVE YOU HAD AN UNPLEASANT DENTAL EXPERIENCE?
☐	☐	b. cold			
☐	☐	c. hot	☐	☐	GRINDING/CLENCHING TEETH WHILE AWAKE OR ASLEEP
☐	☐	d. pressure	☐	☐	CLICKING/POPPING JAW
☐	☐	BAD ODORS IN MOUTH AFTER BRUSHING AND FLOSSING	☐	☐	LUMPS/SWELLING IN MOUTH
☐	☐	RECURRING SORES IN OR AROUND MOUTH	☐	☐	ORTHODONTIC TREATMENT
			☐	☐	AREAS WHERE FOOD COLLECTS

HOW OFTEN DO YOU BRUSH? _____ FLOSS? _____

ARE YOU PLEASED WITH THE APPEARANCE OF YOUR TEETH? _____

WHAT DO YOU THINK THE CONDITION OF YOUR MOUTH IS?

_____ excellent _____ good _____ fair _____ poor

ARE THERE ANY PARTICULAR TREATMENTS YOU WOULD LIKE TO DISCUSS?

_____

_____

NOTES

_____

_____

_____

_____

_____

MEDICAL HISTORY

PHYSICIANS NAME: _____

LAST PHYSICAL EXAM:_____

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure ..... YES NO	Artificial Joints (hip, knee, etc.) ..... YES NO	Hepatitis B or C ..... YES NO
Heart Disease or Attack ..... YES NO	Kidney Trouble ..... YES NO	Venereal Disease ..... YES NO
Angina Pectoris ..... YES NO	Ulcers ..... YES NO	A.I.D.S. ..... YES NO
Congenital Heart Disease ..... YES NO	Diabetes ..... YES NO	H.I.V. Positive ..... YES NO
Heart Murmur ..... YES NO	Thyroid Problems ..... YES NO	Cold Sores/Fever Blisters ..... YES NO
High Blood Pressure ..... YES NO	Glaucoma ..... YES NO	Blood Transfusion ..... YES NO
Arteriosclerosis ..... YES NO	Cosmetic Surgery ..... YES NO	Hemophilia ..... YES NO
Mitral Valve Prolapse ..... YES NO	Emphysema ..... YES NO	Anemia ..... YES NO
Artificial Heart Valve ..... YES NO	Chronic Cough ..... YES NO	Sickle Cell Disease ..... YES NO
Heart Pacemaker ..... YES NO	Tuberculosis ..... YES NO	Bruise easily ..... YES NO
Heart Surgery ..... YES NO	Asthma ..... YES NO	Liver Disease ..... YES NO
Rheumatic Fever ..... YES NO	Hay Fever ..... YES NO	Yellow Jaundice ..... YES NO
Arthritis ..... YES NO	Allergies or Hives ..... YES NO	Epilepsy or Seizures ..... YES NO
Rheumatism ..... YES NO	Sinus Trouble ..... YES NO	Fainting or Dizzy Spells ..... YES NO
Cortisone Medicine ..... YES NO	Radiation Therapy ..... YES NO	Nervousness ..... YES NO
Drug Addiction ..... YES NO	Chemotherapy ..... YES NO	Psychiatric Treatment ..... YES NO
Stroke ..... YES NO	Hepatitis A (infectious) ..... YES NO	Developmentally Disabled ..... YES NO
FEMALES: Are you pregnant ..... YES NO	Are you currently under a doctor's care? YES NO	

MEDICATIONS	ALLERGIES

CONSENT:

1. The undersigned hereby authorizes doctor 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.
2. 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 in connection with (name of patient) _____ _____ . I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

THE PATIENT, GUARANTOR(S) SHALL BE RESPONSIBLE FOR ANY UNPAID BALANCE(S) DUE, PLUS ALL ATTORNEY FEES, COURT COSTS AND/OR COLLECTION AGENCY FEES, TO SATISFY ANY OUTSTANDING BALANCE(S) DUE THIS OFFICE. IF A COLLECTION AGENCY IS USED TO SATISFY AN UNPAID BALANCE, A CHARGE OF THIRTY-THREE (33%) PERCENT WILL BE ADDED TO THE BALANCE. IF AN ATTORNEY IS USED TO SATISFY AN UNPAID BALANCE THE PATIENT WILL BE RESPONSIBLE FOR ALL LEGAL COLLECTION FEES, PLUS COURT COSTS.

I/we have read the above information and understand the contents completely.

_____ _____

Signature of Patient/Guardian/Guarantor Date

_____ _____

Witness Date

Warrenton Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Warrenton Dentistry

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes was updated February 22, 2017, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Protected Health information.

Out-of-Pocket-Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Data Breach Notification Purposes: We may use or disclose your Protected Health information to provide legally required notices of unauthorized access to or disclosure of your health information.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officers: Dr. Vincent J. Murray or Dr. Jamie L. Childress

Warrenton Dentistry
5 Rock Pointe Lane, Suite 100
Warrenton, VA 20186

FINANCIAL POLICY

Our financial policy is designed to provide a clear understanding that the patient is ultimately responsible for payment of all dental services. Because our primary concern is to provide the patient with the best possible dental treatment and to effectively control rising health care costs, we expect payment at the time of service. We accept checks, Visa, MasterCard, and Discover. Ask about outside interest-free financing available through Care Credit. There will be a $30.00 charge for all returned checks.

We are now participating with the Delta Dental Premier, Anthem PPO, Anthem 300, Anthem Federal Employee Program as well as the Cigna PPO plans. As a courtesy to our patients that have a non-participating carrier, we will print a completed claim form with the procedure codes performed for each date of service. To receive this courtesy, subscribers must provide our office with a current dental insurance card. If you have questions regarding your coverage, please call your carrier directly. We do not file or print secondary insurance claims.

To avoid a $50 cancellation fee, please notify this office at least ***two working-days in advance*** if you must cancel an appointment. Patients giving late notice for cancellations more than twice may not be rescheduled. Late cancellations or tardiness affects many patients.

If it has been more than 36 months since your last visit, your file may be deemed inactive and subject to "new patient" policies.

I assign to Dr. Vincent J. Murray and Dr. Jamie L. Childress all moneys entitled to me for the purpose of payment of any unpaid balance resulting from dental treatment received at this facility.

I have read the above information and understand the contents completely.

_____ _____

Signature of Patient/Guardian/Guarantor Date

CONSENT FOR TESTING

In order to comply with the Occupational Safety & Health Administration (OSHA) Blood-borne Pathogen Regulation and Virginia State Law, we are requesting your consent to submit for testing of your blood for blood-borne pathogens Hepatitis B, Hepatitis C or HIV **IF an exposure occurs (needle stick injury, blood splatter) to one of the staff**. Testing will be done at no cost to you. All information regarding an exposure is confidential.

Date: _____ Signature: _____