

Please complete all information requested.

**Patient Information**

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
First MI Last

Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Pager/Cell (\_\_\_\_) \_\_\_\_\_

Birth Date \_\_\_\_\_ SS# \_\_\_\_\_ Occupation \_\_\_\_\_

Full-time Student?  Yes  No School Attending \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced Email address \_\_\_\_\_

In case of emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Are any of your family members patients of this practice?  Yes  No Name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**If the person responsible for the account is different than the patient, please complete:**

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
First MI Last

Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Pager/Cell (\_\_\_\_) \_\_\_\_\_

Birth Date \_\_\_\_\_ SS# \_\_\_\_\_ Occupation \_\_\_\_\_

**Primary DENTAL insurance**

Ins. Co. Name \_\_\_\_\_

Ins. Address \_\_\_\_\_

Ins. Phone (\_\_\_\_) \_\_\_\_\_

Group Plan # \_\_\_\_\_

Effective Date \_\_\_\_\_

Insured Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

**Secondary DENTAL insurance**

Ins. Co. Name \_\_\_\_\_

Ins. Address \_\_\_\_\_

Ins. Phone (\_\_\_\_) \_\_\_\_\_

Group Plan # \_\_\_\_\_

Effective Date \_\_\_\_\_

Insured Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

**Patient Treatment Consent**

I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorized this practice to submit claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.

I agree to be responsible for payment of all services rendered on my behalf to my dependents. I agree that I am responsible for any unpaid claims. I have been made aware of all financial policies of the office.

Patient/Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING – PLEASE CHECK ALL THAT APPLY

Patients's Name \_\_\_\_\_ Date \_\_\_\_\_

	Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints or Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease/Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/tumors	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy/radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care/emotional problems	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Drug/Alcohol Addition	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema or respiratory disorder	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problem	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems (Ulcer/colitis)	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma or eye disorders	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Usage	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis ____	<input type="checkbox"/>	<input type="checkbox"/>	<b>Women:</b>		
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Trying to get pregnant	<input type="checkbox"/>	<input type="checkbox"/>
			Nursing	<input type="checkbox"/>	<input type="checkbox"/>
<b>Allergic reaction (hives or swelling)</b>			Birth Control	<input type="checkbox"/>	<input type="checkbox"/>
Acrylic	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>			
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	<b>WARNING: Antibiotics reduce</b>		
Latex	<input type="checkbox"/>	<input type="checkbox"/>	<b>the effects of birth control pills</b>		
Local Anesthetic (Novocaine)	<input type="checkbox"/>	<input type="checkbox"/>			
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>			
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>			
Other _____					

Do you have any current health problems not listed above? \_\_\_\_\_

If yes, please list \_\_\_\_\_

Are you currently under the care of a physician? \_\_\_\_\_

If yes, please explain why \_\_\_\_\_

Last Medical Exam \_\_\_\_\_

Physician's name and phone number \_\_\_\_\_

Have you ever been hospitalized for any surgery or serious illness? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Have you ever needed to pre-medicate with antibiotics before a dental visit and/or a dental treatment?

If yes, please explain \_\_\_\_\_

Are you currently taking any medications (OTC or Prescription) , Aspirin and/or natural supplements ? If YES, Please List.

Meds \_\_\_\_\_ For \_\_\_\_\_

Meds \_\_\_\_\_ For \_\_\_\_\_

Meds \_\_\_\_\_ For \_\_\_\_\_

# DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Previous Dentist \_\_\_\_\_ When was your last dental visit? \_\_\_\_\_

What treatment was completed? \_\_\_\_\_

So we can better serve you, may we ask why you left your last dental office? \_\_\_\_\_

Have you ever had any serious problem with your previous dental treatment? Yes / No

If yes, please explain \_\_\_\_\_

## DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes	No
Bleeding or tender gums when brushing and/or flossing	<input type="checkbox"/>	<input type="checkbox"/>
Bad taste or constant bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Gum treatment	<input type="checkbox"/>	<input type="checkbox"/>
Loose tooth	<input type="checkbox"/>	<input type="checkbox"/>
Broken filling	<input type="checkbox"/>	<input type="checkbox"/>
Food collecting between teeth	<input type="checkbox"/>	<input type="checkbox"/>
Teeth sensitive to hot, cold, sweets, and/or chewing	<input type="checkbox"/>	<input type="checkbox"/>
Grind or clench your teeth while awake or asleep	<input type="checkbox"/>	<input type="checkbox"/>
Frequent migraines, cluster headaches or earaches	<input type="checkbox"/>	<input type="checkbox"/>
Head, neck or jaw injury	<input type="checkbox"/>	<input type="checkbox"/>
Oral habits, fingernail biting, cheek biting, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Dental braces	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal sores/lumps in or around your mouth	<input type="checkbox"/>	<input type="checkbox"/>
Told or aware that you snore	<input type="checkbox"/>	<input type="checkbox"/>

Have you experienced any of the following in your jaw joints?  
(Please check all that apply)

- Clicking/Popping
- Pain in joint or ear
- Difficulty opening/chewing
- None of the above

Are you happy with your smile? Yes/No  
If NO, what would you like to change?

\_\_\_\_\_  
\_\_\_\_\_

I have provided accurate information to the best of my knowledge related to my medical and dental history.  
I am aware that I am responsible to inform the office of any changes in my health/dental history.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

If Minor, Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Reviewing Dentist \_\_\_\_\_ Date \_\_\_\_\_

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\* 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

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### For Office Use Only

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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)

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# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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## SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Amear M. Tadros

Telephone: 703-430-2020 Fax: 703-430-0303

E-mail: \_\_\_\_\_

Address: 46090 Lake Center Plaza, Suite 202, Potomac Falls, VA 20165

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

## SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**Include completed Consent in the patient's chart.**

# LAKE CENTER FAMILY AND COSMETIC DENTISTRY

## EXPLANATION OF OFFICE POLICIES

Welcome to our office. We are glad you chose our office for you Dental Care.

### **FINANCIAL RESPONSIBILITY**

For our patients with dental insurance coverage, we will be glad to help you obtain the benefit information for your insurance plan and bill your carrier as a courtesy to you. You are responsible for the co-payment which is the difference between our fee and the amount paid by your insurance carrier. (Even if you have double coverage, there may still be a portion that will be your responsibility.) **Please remember that dental insurance benefits are based on a contract between you and the insurance carrier. You are ultimately responsible for your account if your carrier does not pay what is expected.**

### **VERIFICATION OF YOUR DENTAL BENEFITS**

We make every attempt to verify your eligibility and benefits prior to your appointment. As hard as we may try, insurance companies are not always cooperative. If we are unable to verify benefits prior to your visit, you may be asked to pay the fees established by the office on the date of service. We will gladly provide you with a statement that you may present to your insurance company for reimbursement.

### **FORMS OF PAYMENT**

**We gladly welcome Visa, MasterCard, certified bank checks and cash as forms of payment.**

### **PAYMENTS, OVERDUE ACCOUNTS, AND INSUFFICIENT FUNDS**

**Payment is required for all dental care at the time of service. Accounts due greater than 30 days are subject to an 18% annual service charge. In addition, if your account is referred for collection, you will be responsible for an additional 33 1/3% attorney fees.**

### **PAYMENT OPTIONS**

For your convenience, we have established five payment options 1) Payment by appointment 2) Insurance assignment 3) Bank cards, 4) 5% accounting reduction for payment in full before treatment is rendered, 5) Health Care Financing Program (You may qualify to receive a 180 day interest free payment plan)

### **KEEPING YOUR APPOINTMENT**

**Missed appointment times affect many people. The doctor and staff are prepared for your treatment and patients who have been waiting for treatment could have been seen at this time. Please be considerate and call the office to notify us of a cancellation at least 24 hours in advance. We understand that your time is important and we work hard to stay on schedule. Occasionally, emergency procedures cause us to be delayed and we apologize in advance.**

**The fee for cancellation without 24 hour advance notice is \$50. Initial \_\_\_\_\_**

### **REQUEST FOR RECORDS**

All patient records are the legal property of the doctor; however, we will gladly provide you with copies of your x-rays. In accordance with your dental plan and state guidelines, there may be a fee of \$25. Treatment records are computerized and we will gladly provide you with a complete listing of services performed upon request.

### **DENTAL XRAYS AND PHOTOS**

In order to properly diagnose dental disease, you may be advised by the doctor to have X-rays (radiographs) taken AS NEEDED. To assure responsible and accurate diagnosis of most dental diseases, x-rays are a necessary tools to discover what may be lie underneath the hard structures in your mouth . In addition, we will be taking intra oral pictures of your teeth to aid in diagnosis and understanding your dental health. Further, I understand and acknowledge that photographs, x-rays, and/or models of me may be used for the advancement of the art and science of dentistry with prior notice and consent.

***The above information is intended to provide clarification and prevent future misunderstanding. I have read the above and understand the office polices of this office and agree to pay the fees established by this office or by my dental benefit plan.***

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guardian Signature