PATIENT REGISTRATION

ID: ____ Chart ID: ____

First Name: ____ Last Name: ____ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name:

Responsible Party (if someone other than the patient)

First Name: ____ Last Name: ____ Middle Initial: ____

Address: ____ Address 2: ____

City, State, Zip: ____ Pager: ____

Home Phone: ____ Work Phone: ____ Ext: ____ Cellular: ____

Birth Date: ____ Soc Sec: ____ Drivers Lic: ____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ____ Address 2: ____

City: State / Zip: Pager: ____

Home Phone: ____ Work Phone: ____ Ext: Cellular: ____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ____ Age: ____ Soc. Sec: ____ Drivers Lic: ____

E-mail: ____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ____ Pref. Dentist: ____

Employer ID: ____ Pref. Pharmacy: ____

Carrier ID: ____ Pref. Hyg.: ____

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: ____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ____ Insured Birth Date: ____

Employer: ____

Address: ____

Address 2: ____

City,State,Zip: ____

Ins. Company: ____

Address: ____

Address 2: ____

City,State,Zip: ____

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: ____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ____ Insured Birth Date: ____

Employer: ____

Address: ____

Address 2: ____

City,State,Zip: ____

Ins. Company: ____

Address: ____

Address 2: ____

City,State,Zip: ____

Rem. Benefits: ____.00 Rem. Deduct: ____.00

MEDICAL HISTORY

PATIENT NAME ____ Birth Date ___________________________________

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 ◯ No If yes, please explain: ___________________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ___________________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ___________________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ___________________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ___________________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ___________________________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ___________________________

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	◯	◯	Cortisone Medicine	◯	◯	Hemophilia	◯	◯	Radiation Treatments	◯	◯
Alzheimer's Disease	◯	◯	Diabetes	◯	◯	Hepatitis A	◯	◯	Recent Weight Loss	◯	◯
Anaphylaxis	◯	◯	Drug Addiction	◯	◯	Hepatitis B or C	◯	◯	Renal Dialysis	◯	◯
Anemia	◯	◯	Easily Winded	◯	◯	Herpes	◯	◯	Rheumatic Fever	◯	◯
Angina	◯	◯	Emphysema	◯	◯	High Blood Pressure	◯	◯	Rheumatism	◯	◯
Arthritis/Gout	◯	◯	Epilepsy or Seizures	◯	◯	High Cholesterol	◯	◯	Scarlet Fever	◯	◯
Artificial Heart Valve	◯	◯	Excessive Bleeding	◯	◯	Hives or Rash	◯	◯	Shingles	◯	◯
Artificial Joint	◯	◯	Excessive Thirst	◯	◯	Hypoglycemia	◯	◯	Sickle Cell Disease	◯	◯
Asthma	◯	◯	Fainting Spells/Dizziness	◯	◯	Irregular Heartbeat	◯	◯	Sinus Trouble	◯	◯
Blood Disease	◯	◯	Frequent Cough	◯	◯	Kidney Problems	◯	◯	Spina Bifida	◯	◯
Blood Transfusion	◯	◯	Frequent Diarrhea	◯	◯	Leukemia	◯	◯	Stomach/Intestinal Disease	◯	◯
Breathing Problem	◯	◯	Frequent Headaches	◯	◯	Liver Disease	◯	◯	Stroke	◯	◯
Bruise Easily	◯	◯	Genital Herpes	◯	◯	Low Blood Pressure	◯	◯	Swelling of Limbs	◯	◯
Cancer	◯	◯	Glaucoma	◯	◯	Lung Disease	◯	◯	Thyroid Disease	◯	◯
Chemotherapy	◯	◯	Hay Fever	◯	◯	Mitral Valve Prolapse	◯	◯	Tonsillitis	◯	◯
Chest Pains	◯	◯	Heart Attack/Failure	◯	◯	Osteoporosis	◯	◯	Tuberculosis	◯	◯
Cold Sores/Fever Blisters	◯	◯	Heart Murmur	◯	◯	Pain in Jaw Joints	◯	◯	Tumors or Growths	◯	◯
Congenital Heart Disorder	◯	◯	Heart Pacemaker	◯	◯	Parathyroid Disease	◯	◯	Ulcers	◯	◯
Convulsions	◯	◯	Heart Trouble/Disease	◯	◯	Psychiatric Care	◯	◯	Venereal Disease	◯	◯
									Yellow Jaundice	◯	◯

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ___________________________

Comments: ___________________________

____

____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ___________________________ DATE ______________

Dental History

Date of last dental visit?
_____/_____/_______

Date of last dental x-rays?
____/_____/________

Former Dentist:_______________________________

City/State:____________________________________

Reason for today's visit?
____

Do you have any concerns about this visit?

____

Bleeding Gums?
YES NO

Bad Breath?
YES NO

Blisters on lips or mouth?
YES NO

Burning sensation on tongue?
YES NO

Loose teeth or broken fillings?
YES NO

Have you ever been told you have gum disease?
(Periodontal treatment)
YES NO

Gums swollen or tender?
YES NO

Are your teeth sensitive?
YES NO

Have you ever had any pain in your jaw joints?
(clicking or poping)
YES NO

Jaw pain or tiredness?
YES NO

Lip or cheek biting?
YES NO

Mouth Breathing?
YES NO

Mouth pain with brushing?
YES NO

Chew on one side of mouth?
YES NO

Cigarette, pipe, vape, or cigar smoking?
YES NO

Grinding teeth?
YES NO

Dry Mouth?
YES NO

Fingernail Biting?
YES NO

Food collecting between the teeth?
YES NO

Orthodontic treatment?
YES NO

Pain around ear?
YES NO

Sores or growths in mouth?
YES NO

How often do you floss? _______________

How often do you brush?______________

***Please be aware that our office **only** uses **tooth color composite** filling material. ***

These fillings are **not always** being covered by insurance companies, in turn making the balance the patients' responsibility.

Please contact your insurance company for any questions on whether they will cover your fillings.

__________________________ __________________

SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Robert G. Java, D.D.S.
3401 Commission Court, #202
Woodbridge, VA 22192
703-494-7799

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("**HIPAA**"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physicians certifications.**

I have received, read and understood your Notice of Privacy Practices containing a more complete descriptions of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from the time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name ____

Relationship to Patient _______________________________________

Signature __________________________ Date _______________

Release of my information to: ______________________________________
(Please write down the names…Spouse, Child, Friend, ect…)

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____________ Initials: _______________ Reason: _____________________________

Dr. Robert G. Java, D.D.S.
3401 Commission Court #202
Woodbridge VA22192
703-494-7799

Our Office and Financial Agreement

Thank you for choosing our dental practice. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following statement of our Financial Policy that we require you to read, initial, and sign prior to any treatment.

If you are a patient of record please update any information, concerning your medical history or insurance that may have changed since your previous visit with us. We also ask that your read, initial, and sign this statement if you have one on file.

Regarding Primary Insurance

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. *You are responsible for payment regardless of what any insurance company determines to be a usual and customary rate.

If you have insurance coverage with a PPO plan, as a courtesy, we will be glad to file the necessary forms for payment or reimbursement, with your cooperation. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us the correct information to do so. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days of the billing date, the balance will incur a finance charge of eighteen percent (18%) per year (1.5% a month). **Please be aware that some, and perhaps all, of the services provided may be non-covered services.** Payments under Financial Agreements must also be made in a timely manner and are subject to the same terms hereunder.

Initial _____

Regarding Secondary Insurance

If you have secondary insurance we will give you all the appropriate paper work you need to file it on your own. If you have any questions on how to file we will be glad to assist you.

Initial _____

All Co-pays and deductibles are due at the time services are rendered

We accept cash, checks, Visa, MasterCard, and Discover. Any returned checks will incur a $35.00 returned check fee. In an unlikely event collection on a patients account might become necessary, any associated court fees any costs associated therewith (all of which are estimated to total 30% in addition to any outstanding balance), will become the patient's obligation.

Initial _____

Third Party Financing

With prior approval, we are pleased to offer a choice of No Interest Extended Payment Plans to qualified applicants. If you would like to make extended payments for services provided at our office, please ask any of our administrative team for assistance in filling out an application form.

Missed Appointments

If you are unable to keep a reserved appointment we ask that you kindly provide us with a minimum of **two business days notice**. Our office does not accept changes to reserved appointments after hours by voicemail. We prefer to speak to you directly during business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. **Office Hours: Monday – Wednesday 8am-5pm; Thursday 7am-5pm; Friday 7am-12pm**

Initial _____

Thank you for understanding our office Financial Agreements. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to the Financial Policy.

We look forward to having you and your family as our patients and continuing to providing the quality care you expect, and we strive to provide.

X______________________________ X______________________________ X__________

Signature of Patient or Responsible Party | Print Patient's Name | Date