Patient Information

Personal Information

First Name: ______________________________ Middle Initial: ______ Last Name:________________________________

Preferred Name: __________________________

Date of Birth: ___________________ Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Child

Street: ____

City: ____ State: ___________ Zip: __________________________________

Home Phone: ____________________________________ Work Phone: ____

Cell Phone: _____________________________________ Email Address: _____________________________________

Preferred Contact Method: ☐ Home ☐ Work ☐ Cell ☐ E-mail

Student Status if Dependent Over Age 19: ☐ Non-student ☐ Full-time ☐ Part-time

Emergency Contact: ____ Emergency Phone #: ______________________

How did you hear about us? ____

Primary Dental Insurance

Your relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: ____ Subscriber ID #:_____________________________

Subscriber Date of Birth: ______________________________

Insurance Company: _________________________________ Insurance Phone Number: ___________________________

Employer Name: ____________________________ Group Name: ______________ Group #: ______________________

Secondary Dental Insurance

Your relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: ____ Subscriber ID #:_____________________________

Subscriber Date of Birth: ______________________________

Insurance Company: _________________________________ Insurance Phone Number: ___________________________

Employer Name: ____________________________ Group Name: ______________ Group #: ______________________

Medical History

Last Name: ____________________ First Name: ____________________ Birthdate: ____________________

Name of Medical Doctor: ______________________________ City/State: ____________________

List all medications that you take:

____
____
____
____
____
____
____
____
____
____
____
____
____

Please mark whether or not you have the following allergies.

Y	N	
☐	☐	Local Anesthetics
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Ibuprofen, naproxen or NSAIDS
☐	☐	Iodine
☐	☐	Latex
☐	☐	Penicillin or Amoxicillin
☐	☐	Sulfa
☐	☐	Morphine
☐	☐	Keflex or other Cephalosporins
☐	☐	Other Drug Allergies
☐	☐	Other Food or Environmental Allergies

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

Y	N	
☐	☐	Asthma
☐	☐	Bleeding Problems
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Heart Murmur
☐	☐	Heart Attack
☐	☐	High Blood Pressure
☐	☐	Heart Failure
☐	☐	Artificial Heart Valves
☐	☐	Irregular heartbeat or palpitations
☐	☐	COPD or other Lung Disease
☐	☐	Smoke Tobacco
☐	☐	Joint Replacement
☐	☐	Pacemaker or Defibrillator
☐	☐	Radiation treatment
☐	☐	Pregnant Now / Could Possibly be Pregant

Y	N	
☐	☐	Kidney Disease
☐	☐	Kidney Failure or Dialysis
☐	☐	Liver Disease
☐	☐	Hepatitis
☐	☐	Sinus Trouble
☐	☐	Stroke
☐	☐	Ulcers
☐	☐	Rheumatic Heart Disease
☐	☐	Sleep Apnea or gasp for air when sleeping
☐	☐	Family or personal problem with anesthesia
☐	☐	Thyroid Disease
☐	☐	Skin Disease
☐	☐	Arthritis
☐	☐	Back Problems
☐	☐	Psychiatric Treatment
☐	☐	Other Health Problems

Unusual reaction to dental injections? ______________________________

Reason for today's visit: ______________________________ Are you in pain? ____________________

New patients:

Do you have x-rays available for your visit today? ______________________________

Who referred you to us? Or how did you hear about us?______________________________

Name of Former Dentist: ______________________________ City/State:____________________

Date of last cleaning and exam: ______________________________

Today's Date:

Financial Agreement

Thank you for choosing Pinebrook Dentistry as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Do You Have Insurance?

- As your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims and receive payment directly from them. We will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or outside patient financing at the time we provide the service to you.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance up to 35%. Returned checks will be subject to additional fees. Broken appointments without 24-hour notice may incur $50.00 missed appointment fee.

____ ____________________

Last Name, First Name Date of Birth

____

Signature

____

Date

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

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, or to family and friends you approve.

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. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

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 or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

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 with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

Acknowledgement of Receipt of Notice of Privacy Practices

Notice of Privacy Practices

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

____ ____________________
Last Name, First Name Date of Birth

____
Signature

____
Date

Authorization for Release of Health Records to External Parties (Optional)

I authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

____ ______________________________
Name (Printed) Relationship

____ ______________________________
Name (Printed) Relationship

____ ______________________________
Name (Printed) Relationship

Records Release Request

Patient:____

Patient's Date of Birth: ______________________________

To (Doctor/ Physician): ____

Address:____

City: ______________________________________ State: _____________ Zip: ________________

Phone: ___________________________________ Fax: ____________________________________

I authorize the release of dental records relevant to dental treatment, including x-rays, charting and photographs, and request that they be transferred to:

Pinebrook Dentistry
Gloria Kim, DDS
24805 Pinebrook Road., Suite 311
Chantilly, VA 20152
Telephone: (703) 574-9070 Fax: (703) 574-9071
Email: info@pinebrookdentistry.com

____ ________________________________
Signature of Patient or Legal Representative Date