# alexandria dental group

COSMETIC • IMPLANT • FAMILY DENTISTRY

1600 Duke Street #150, Alexandria VA 22314 • www. ALXdental .com • 703-276-1110 • contact@ALXdental.com


## Personal Information

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Patient's Last Name | First Name | Middle Initial

Preferred Name / Nickname

(Responsible Party's Name, if not the patient) | (Relationship to Patient)

Patient Sex: ◯ Male ◯ Female

Date of Birth | Social Sec. Number

Cell Number :

Home Number :

Work Number :

E-mail :

Home Address

City | ST | ZIP

Name of Employer (or school)

Occupation (or field of study)

Employer's Address (or school address)

Marital Status: ◯ Married ◯ Unmarried

Full Name of Spouse

Spouse's Employer (Name & City)

Spouse's Work Tel.

Who may we thank for referring you to our office? (or please tell us how you heard of us)

Which other family members are patients at this office?

## Insurance Information

Subscriber's Name (e.g. name of head of household)

Name of Subscriber's Employer

Subscriber's Date of Birth | Subscriber's Soc. Sec. Number | Subscriber's Relationship to Patient (e.g., self / spouse)

Insurance Company & Plan Name | Group ID Number | Subscriber ID Number

## Emergency Contact Information

Name of Emergency Contact | Relationship to Patient

Home Telephone Number | Work Telephone Number | Cell or Other Telephone Number

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# Patient Medical & Dental Information Form

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Patient's Last Name _____ Patient's First Name _____ Middle Initial _____

## Dental History & Cosmetic Treatment Options

Date of Last Dental Visit: _____ Former Dentist: _____

Date of Last X-rays: _____ ... in City, State: _____

◯ Yes ◯ No Do you feel that your mouth (or jaw) functions properly?

◯ Yes ◯ No Are you happy with the appearance of your teeth/smile?

◯ Yes ◯ No Are all of your teeth in alignment (straight)?

If you could, what would you like to change about your teeth/smile? _____

◯ Yes ◯ No Do you have any old fillings, crowns, or dental treatment(s) that you are concerned about or unhappy with?

Please let us know if you would like information about any of the following:

☐ Invisalign (clear braces) ☐ Porcelain veneers ☐ Whitening / Bleaching ☐ Making teeth look taller ☐ Closing gaps between teeth

◯ Yes ◯ No Are you fearful of dental treatments?

If YES, rate your fear level from 1 (some fear) to 10 (incredibly fearful) _____

What is the trigger for your fear? (check all that apply) ☐ Needles ☐ Smells ☐ Sounds ☐ Fear of pain

### Check if you have had problems with any of the following:

| | | |
|---|---|---|
| ☐ Bad breath | ☐ Food collection between teeth | ☐ Periodontal (gum) treatment |
| ☐ Bleeding gums | ☐ Grinding/clenching teeth | ☐ Prolonged bleeding after extraction |
| ☐ Clicking or popping jaw | ☐ Headaches | ☐ Sensitivity to biting/chewing |
| ☐ Difficult opening or closing of jaw | ☐ Jaw pain or tiredness | ☐ Sensitivity to cold/hot/sweets |
| ☐ Difficult extractions in the past | ☐ Loose teeth or broken fillings | ☐ Sores, lumps, growths in your mouth |
| ☐ Dry mouth | ☐ Orthodontic treatment | ☐ Swollen or tender gums |

## Medical History

Date of Last Physician Visit: _____ Name of Physician: _____

... in City, State: _____ Tel. No.: _____

◯ Yes ◯ No Have you had any serious illnesses, operations, or hospitalizations? If YES, please give dates and reason: _____

◯ Yes ◯ No Have you ever had a blood transfusion? If YES, please give dates and reason: _____

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## Check any of the following which apply to you:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis -or- Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints/Replacements
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical / Drug Addiction
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough -- Persistent or Bloody
- ☐ Diabetes -- Type (1 or 2): _____
- ☐ Emphysema
- ☐ Epilepsy / Seizures
- ☐ Fainting / Dizziness
- ☐ Frequently Tired
- ☐ Glaucoma
- ☐ Hay Fever / Seasonal Allergies
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmurs / Irregular Beat
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis - Type: _____
- ☐ Herpes / Cold Sores (blisters)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash / Hives
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

## Medications you are currently taking: (including over-the-counter)

_____ _____

_____ _____

## Women only:

◯ Yes ◯ No Are you currently pregnant? (or think that you might be?)

◯ Yes ◯ No Are you nursing?

## Tobacco user? ◯ Yes ◯ No

What kind, how many years, how often? _____

_____

## Are you currently taking or have you taken any of the following?

- ☐ Fen-Phen/Redux
- ☐ Actonel
- ☐ Boniva
- ☐ Fosomax

## Vitamins / Minerals / Supplements / Herbal:

_____

_____

## Allergies:

- ☐ Aspirin
- ☐ Barbiturates (e.g. sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic (e.g. Novocaine)
- ☐ Antibiotics (e.g. Penicillin)
- ☐ Sulfa
- ☐ Others: _____

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## Insurance Benefits and Claims Policy

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GENERALLY: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, or if your insurance company has not paid your account in full within 60 days from the date the services were rendered, the balance will become payable immediately, regardless of any pending claims. We require that your complete insurance information be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

MAINTAINING HIGH STANDARDS FOR CARE: Please be aware that some, and perhaps all, of the services provided may be non-covered services, or may have a charged fee not considered "reasonable and customary", or may be deemed an unnecessary service according to administrators of your insurance policy. The decision(s) of your insurance policy's administrators, particularly regarding the necessity of treatment, are outside of our control. Our practice is committed to providing the best dental care for you, determined by professional and skilled dentists examining you, rather than administrators examining charts and figures about your or the service rendered. Also, we strive to maintain the highest standards in terms of sterilization, materials and laboratory services for our patients. As such, we choose not to allow administrators of insurance policies to compromise our level of care or standards, and trust that our patients appreciate our efforts in this regard. Therefore, each patient joining our practice agrees to be responsible for paying their full balance, less insurance payments received, despite any insurance company's determination regarding the necessity or usual and customary fees charged for services rendered at our office.

FILING CLAIMS: As a courtesy to our patients, we will do our best to verify your dental insurance benefits and also answer any questions you may have about insurance claims. However, each patient is responsible for knowing their insurance plan's coverage, exclusions, limitations and usage history. Furthermore, each patient should be aware of non-covered benefits, including missing tooth clauses, crown/bridge/denture restoration time and frequency limits, bruxism, downgrades (e.g. composite fillings to amalgam fillings, onlays/inlays to fillings, porcelain on molar teeth crowns, etc.), and other frequency limits (e.g. exams, prophylaxis, fluoride, x-rays). Any estimated amount not expected to be covered by your insurance is due at the time of treatment. Please note that all insurance estimates are subject to final approval by your dental insurance plan, and therefore the amount due is subject to change after final review by your insurance company.

ADDITIONAL LAB FEES: In certain situations, additional lab fees may be necessary and are an additional cost for such procedures (e.g. zirconia crowns, veneers, porcelain margins, etc.). You will be advised of any additional lab costs prior to the start of treatment and are responsible for such fees.

RESIN-BASED COMPOSITE FILLINGS: Most dental insurance plans do not allow full benefits for composites (white fillings), especially when performed on posterior (back) teeth. The plan benefit will customarily pay for less expensive amalgam fillings, which are silver/mercury based. In an effort to provide our patients the highest level of modern dental care, we do not provide amalgam fillings, and only provide composites. The difference is usually $50-75 per filling and the patient is responsible for paying for the difference.

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## Office Policy & Patient Consent/Releases

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I authorize the dentists and staff at this dental office to provide any and all forms of treatment and medication that may be necessary or advisable in connection with my (or my dependent's) dental care. I further consent to the dentists and staff choosing and employing such methods and means as is deemed fit. I understand that prior to treatment, a full explanation of the procedure(s) involved will be given to me, and I agree to ask any questions that I may have, and to raise any issues, prior to the start of the treatment. Also, I understand that there are rare but real risks associated with local anesthesia such as permanent or temporary paresthesia. I understand those risks and will ask any questions that I may have prior to treatment, and consent to local anesthesia being administered to me as part of my dental treatment.

I authorize the dentists and staff to take photographs, study models, and/or radiographs of my face, jaws, and teeth. I understand that these photographs, study models, and/or radiographs will be used as a record of my care and treatment, and further authorize their use for educational or teaching purposes by this office and this office only.

In consideration of services rendered, I transfer and assign to Alexandria Dental Group all rights and interest in any payment due for services as provided in the policy or policies of dental insurance(s) held by me. I understand that I am legally responsible for all cost of treatment, regardless of any estimated insurance balance, and that my portion for covered procedures may differ from estimates provided by this dental office. I further agree and authorize the dental office to release any information requested by my insurance company(s) or its representatives. If the dentists are not direct providers for my dental insurance provider, I understand that filing a claim with my dental insurance may be done strictly as a courtesy to me, and that I still remain liable for the full amount of fees for services rendered.

I understand and agree that any and all past due balances over thirty (30) days will be subject to a finance charge of 1.5% per month (18% annually). I further agree that where collection activities are employed, whether via collection agencies or legal proceedings, in order to collect any delinquent amounts owed by me, I shall be responsible for all costs of collection, including but not limited to, court costs, interest, and attorney fees in the amount of 33 and 1/3% of the total principal and interest owing on my account, whether or not formal litigation is instituted.
In the event that my check is returned for NSF or another reason, I agree to pay a non-refundable fee of $50. For any refund or amount issued back to my credit card account, I agree to pay a fee equal to 3% of the transaction being refunded.

I understand that pursuant to Virginia Code 32.1-45.1, any patient who exposes a health care provider (or employee) to bodily fluid in a manner which may transmit the Human Immunodeficiency Virus (HIV), Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis B and C testing, and disclosure of the results to the person exposed. Conversely, this deemed consent also applies to a health care provider (or employee) who exposes a patient to bodily fluid in same manner. In the case the above stated condition occurs, I agree to comply fully and immediately with the above referenced Code.

If necessary, I agree to cancel or reschedule any appointment at least two business days prior to my appointment time in order to avoid a $50 non-refundable cancellation fee. I also agree that being substantially late for an appointment, or missing an appointment altogether, shall be deemed a cancellation and that the cancellation fee will apply.

Signature

I have read and understood this entire agreement before signing here below, and I have endorsed this agreement voluntarily, without duress, and of my own free will and choice. I certify that the information I have provided, especially regarding my medical history, is accurate and that I understand that incorrect or incompleted information being provided may be dangerous to my health. I also agree to abide by the office's policies, including its payment and financial policies. Furthermore, I have reviewed and accept the office's "Notice of Privacy Practices (HIPAA)" that is available both on the office's website as well as at the office upon request.

Name of Patient or Representative (please PRINT): _____

Signature of Patient (or Representative): _____ Date: _____

# Records Release / Request
## (for sending records to Alexandria Dental Group)

To: _____
Doctor / Practice Name

Address: _____
Doctor / Practice Street Address

_____
City ST ZIP Code

I hereby authorize the release of my records, including treatment plans or notes, and most recent x-rays (both bite-wings and panoramic), to the following office:

**Alexandria Dental Group**

1600 Duke Street #150

Alexandria, VA 22314

Please prepare and...

☐ mail to the office above OR ☐ hold for me to pick up OR ☐ FAX them to 703-763-4362 OR ☐ E-mail them to: contact@ALXdental.com

**SPECIAL NOTE REGARDING MY X-RAYS:**

If my x-rays are maintained in electronic form, instead of providing them in printed form, please e-mail them in their **original / maximum** and **full-size**, in either "JPG" or Dentrix's "VNS" format, to: contact@ALXdental.com

Patient Printed Name: _____ Patient Date of Birth: _____

Patient Signature: _____ Date: _____

Patient Telephone: _____