Manassas Modern Dentistry

Welcome to Manassas Modern Dentistry. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ **Date of birth:** _____ **Sex:** _____ **Age:** _____

Home address: _____ **City:** _____ **State:** _____ **Zip:** _____

Billing address (if different): _____ **City:** _____ **State:** _____ **Zip:** _____

Home phone: _____ **Cell:** _____ **E-mail:** _____

Driver's license #: _____ **State:** _____**Marital Status:** _____

SS #: _____ **Employer/Occupation:** _____ **Bus. Phone:** _____

Spouse's name & phone #: _____ **Emergency phone # (other than spouse):** _____

Primary dental insurance: _____ **Group #:** _____

Secondary dental insurance: _____ **Group #:** _____

Subscriber's name: _____ **Date of birth:** _____ **SS #:** _____

Name of your medical doctor: _____ **Date of last visit to medical doctor:** _____

Name of previous dentist: _____ **Date of last visit to dentist:** _____

Referred to us by: _____ _____

DENTAL INFORMATION	Y	N	DENTAL INFORMATION	Y	N
Do your gums bleed when you brush or floss?			Do you have earaches or neck pains?		
Are your teeth sensitive to cold, hot, sweets or pressure?			Do you have any clicking, popping or discomfort in the jaw?		
Does food or floss catch between your teeth?			Do you brux or grind your teeth?		
Is your mouth dry?			Do you have sores or ulcers in your mouth?		
Have you had any periodontal (gum) treatments?			Do you wear dentures or partials?		
Have you ever had orthodontic (braces) treatment?			Do you smoke?		
Have you had any problems associated with previous dental treatment?			Have you ever had a serious injury to your head or mouth?		
Is your home water supply fluoridated?			Date of your last dental exam:		
Do you drink bottled or filtered water?			What was done at that time?		
If yes, how often? Circle one: DAILY/WEEKLY/ OCCASIONALLY			Date of last dental x-rays:		
Are you currently experiencing dental pain or discomfort?			How do you feel about your smile?		
What is the reason for your dental visit today?					
MEDICAL INFORMATION	**Y**	**N**	**MEDICAL INFORMATION**	**Y**	**N**
Are you now under the care of a physician?			WOMEN ONLY:		
Are you in good health?			Are you PREGNANT?		

Have you had a serious illness, operation or been hospitalized in the past 5 years?			Number of weeks: _____		
If yes, what was the illness or problem?			Are you taking birth control pills or hormonal replacement?		
			Are you Nursing?		
Has there been any change in your general health within the past year?					

ALLERGIES - Are you allergic to or have you had a reaction? If yes, please specify type of reaction.					
	Y	N		Y	N
Local anesthetics			Metals		
Aspirin			Latex (rubber)		
Penicillin or other antibiotics			Iodine		
Barbiturates, sedatives, or sleeping pills			Hay fever/seasonal		
Sulfa drugs			Animals		
Codeine or other narcotics			Food		

HEALTH INFORMATION	Y	N	HEALTH INFORMATION	Y	N	HEALTH INFORMATION	Y	N	HEALTH INFORMATION	Y	N
Cardiovascular disease			Mitral valves prolapse			AIDS or HIV infection			Tuberculosis		
Angina			Pacemaker			Rheumatoid arthritis			Gastrointestinal disease		
Arteriosclerosis			Rheumatic fever			Asthma			G.E. Reflux/heartburn		
Congestive heart failure			Rheumatic heart disease			Bronchitis			Ulcers		
Damaged heart valves			Abnormal bleeding			Emphysema			Thyroid problems		
Heart attack			Anemia			Sinus trouble			Epilepsy		
Heart murmur			Hemophilia			Chest pain upon exertion			Fainting spells or seizures		
Low blood pressure			Arthritis			Chronic pain			Sleep disorder		
High blood pressure			Autoimmune disease			Eating disorder			Diabetes Type I or II		
Other congenital heart defect			Blood transfusion DATE:			Systemic lupus erythematosus			Cancer/Chemotherapy/ Radiation Treatment		
Stroke			Glaucoma			Malnutrition			Osteoporosis		
Kidney problems			Excessive urination			Severe weight loss			Skin Rash		
Hepatitis, jaundice, or liver disease			Severe headaches/ migraines			Persistent swollen glands in neck			Sexually transmitted disease		
Recurrent Infections			Neurological disorders			Mental health disorders			Other:		

Artificial (prosthetic) heart valve	Y	N	Do you wear contact lenses?	Y	N
Previous infective endocarditis			Have you had an orthopedic total joint replacement?		
Damaged valves in transplanted heart			Please list all medication you are taking including vitamins, natural or herbal preparations:		
Congenital heart disease (CHD)					
Unrepaired, cyanotic CHD					
Repaired (completely) in last 6 months			Physician Name:		
Repaired CHD with residual defects			Physician Phone:		

NOTE: Both Doctor and patient are encouraged to discuss all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this page.

Signature of Patient/Legal Guardian: _____ Date: _____

Manassas Modern Dentistry

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgement if you wish.

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

_____ _____

Signature of patient or parent/legal guardian/legally responsible person Date

_____

Description of relationship to patient

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from the patient, but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

_____

_____

_____

_____ _____

Employee signature Date

Manassas Modern Dentistry

OFFICE POLICY

Our Approach to Dentistry

Welcome to our practice. Preventive dentistry is our goal for every patient. It involves the daily care, good nutrition, periodic check-ups, and cleanings that maintain good dental health. Preventative dentistry may not be where we start with every patient, but it is where we like to finish. Restorative dentistry is basic repair of the mouth. We replace broke or leaky fillings, build crowns and bridges, and fit partials. We aggressively treat gum disease and can perform most root canal therapy. Cosmetic dentistry is coming of age with new materials and procedures that can make a smile beautiful. For those considering cosmetic treatment we can fill in the gaps, chips, and restore the less than a perfect smile.

Infection Control: Our office is keenly aware that HIV, Hepatitis B, Influenza. Tuberculosis, and many other pathogenic (disease producing) bacteria are communicable. With the invasion of the HIV virus, we double out efforts to achieve the most sterile dental environment possible. Our aim is to find the best that technology has to offer to keep the practice safe for our patients and our staff. We meet and exceed the infection control standards of the American Dental Association and Centers for Disease Control. Our rigid protocols are familiar: masks, gloves, and eye protection. But other safeguards are more subtle. We use the best methods to sterilize our instruments and use as many disposable items as possible to diminish the chance of cross-contamination. Staff members are meticulous in the disinfection of furniture, trays, and counters between every patient. Our patients deserve the highest standards possible, and we wouldn't have it any other way.

Composite Resin Fillings: Composite resins are our restoration material of choice for several reasons. Their cosmetic properties are unsurpassed and their marginal adaptation where enamel and resin meet are excellent. This type of filling fits extremely well. By building up the material in layers, and curing as we go, the filling actually strengthens the tooth structure, whereas amalgam (silver) fillings can weaken the tooth over time. Placement of composite fillings require removal of less tooth structure than silver fillings. In many cases, they can be placed without anesthesia.

Emergency Care: At Caring Dental, we know that dental emergencies often happen after practices are closed. That's why we have a dentist on call seven days a week to handle after-hour dental emergencies for our patients.

Fluoride Treatment: It is our office policy to give all patients fluoride treatment after routine cleaning appointments. With the increased usage of bottled water, which does not contain fluoride, we are attempting to supplement the only daily fluoride many patients are getting using conventional toothpaste. Depending on your insurance coverage, there may be a fee up to $40.00. If you agree to have fluoride at your routine cleaning appointments, please initial here _____.

_____ _____

Signature of patient or parent/legal guardian/legally responsible person Date

_____

Manassas Modern Dentistry

Consent for Services and Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

GENERAL:

Thank you for choosing our 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 is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER & CARE CREDIT

DENTAL INSURANCE:

Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your ***ESTIMATED*** co-payment on the day services are rendered. We will gladly file your insurance claim. Many variables exist from carrier to carrier (i.e., deductibles, annual maximums, allowable fee limitations, non-covered procedures, and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. After a statement of accounts has been sent and a balance is left on the account after 60 days, the credit card kept on file will be charged for any balance over 60 days.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All ESTIMATED portions and deductibles are due prior to treatment. In the event YOUR insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment.

USUAL AND CUSTOMARY RATES

Our practice is committed in 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 any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS Adult patients are responsible for full payment at time of service.

MINOR PATIENTS The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized

to be approved by Visa/MasterCard, American Express, Discover, Care Credit, or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS We respectfully ask that you give us a minimum of 48 hours' notice to cancel or reschedule your appointment. Please help us serve you better by keeping scheduled appointments.

AUTHORIZATION & RELEASE:

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize my personal payment information (checks or credit cards used to make payments on your account), to be kept on file, if needed, to make restitution on any balance over 60 days past due. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I agree to have any photos taken of me to be used for education, training and/or marketing. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent, or guardian

Manassas Modern Dentistry

Missed Appointment Policy

Our goal is to provide quality health care to all our patients in a timely manner. No shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call our office at **703-361-2911** as soon as you know you will not be able to make your appointment.
If cancellation is necessary, we require that you call at least **24 hours** in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment

If you need to cancel your appointment, please call us at **703-361-2911** between the hours of [9 am -6 pm]. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a **$50.00** missed appointment fee.

For new patients' first appointments, a no show or late cancellation will result in a full charge of **$50.00**

DATE: …… SIGNATURE: ……

NAME/RELATION: ……

INFORMED CONSENT

You have the right to accept or reject dental treatment recommended by your dentist. This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, alternative treatments or the option of no treatment.

It is very important that you provide your dentist with an accurate medical history before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Please read the items below and sign at the bottom of the form.

During your course of treatment the following care will be provided to you:

_____ **Examination and X-Rays** X-Rays are required to complete your examination, diagnosis and treatment plan. A periodic examination will be provided by the dentist at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer and overall health.

_____ **Dental Prophylaxis (Cleaning)** A routine dental prophylaxis involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. Some bleeding after a cleaning can occur, however, should it persist and if it is severe in nature the office should be contacted.

_____ **Scaling and Root Planing (SRP/Deep Cleaning)** This treatment involves removing the bacterial substance known as plaque, which is the principal cause of periodontal disease and calculus (tartar), which is an accumulation of hard deposits on the tooth above or below the gingival margin. A topical and/or local anesthetic may be administered depending on the sensitivity of the area to be treated. The success of the treatment depends in part on your efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow proper home care taught to you by this office.

I understand that because cleanings involve contact with bacteria and infected tissue in my mouth, I may also experience an infection, which would be treated with antibiotics.

I also understand that after the procedure I may experience:

- Post-Operative discomfort and swelling that may persist for several days.
- Stretching of the corners of the mouth with resultant cracking and bruising.
- Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side: this may persist for several days, weeks, months, or in some instances, permanently.
- Swelling, bruising, and bleeding of the gum tissue.
- Shrinkage of the gum tissue.
- Sensitivity of the teeth.
- Loosening of the teeth.
- Exposure of margins of previous crowns or caps.

_____ _____

Patient Signature Date