Fairlington Dental
4850 South 31st St. Ste. A * Arlington, VA 22206 * 703-671-1101

Patient Information

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)

Gender: ________ Family Status: ________________

Social Security #: ______________________________ Birth Date: ____________________________

Phone (Home): ______________ (Work): ______________ Ext: ________ (Cell): ____________________

Address: ____
Street Apartment #

____
City State Zip Code

Email Address: ______________________ _____@__________________________

Emergency Contact Information

Names and relationships of others who we may contact in case if an emergency:

Name: ____

Relationship: ______________________________ Phone: ____________________________________

Name: ____

Relationship: ______________________________ Phone: ____________________________________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: __________________________________ Occupation: ___________________________

Address: ____
Street City, State Zip Code Phone

Dental Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ________________ ID #: ____________________ Group #: ____________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ________________ ID #: ____________________ Group #: ____________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

Insurance Plan Name and Address: ____

____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Another patient, relative
☐ Dr. / Dental Office ☐ Magazine Ad ☐ TV Show ☐ School ☐ Work ☐ Other ______________________

Name of person or office referring you to our practice: ____

Health Information

Date of Last Dental Visit: __________________ Reason for last visit: ___________________________________

Please indicate YES for current medical conditions by marking the box beside each that apply:

☐ AIDS / HIV
☐ Allergies __________ __________
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer,Type:_______
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Snoring
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Premedication

Current Medications:
____
____
____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: _______________________________________ Phone: __________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

Dental History

Please Circle Yes or No:

- Would you like whiter teeth? Yes No (If yes, please feel free to ask any team member)
- Do your gums bleed? Yes No
- Are you concerned about your breath? Yes or No
- Do you have any sores or lumps in or near your mouth? Yes No If yes, where ______________
- Do you snore while sleeping? Yes No Have you been diagnosed with Sleep Apnea? Yes No
- Do you have or have you ever had any of the following? (Please mark box)

☐ Pain in your jaw joints
☐ Soreness when chewing
☐ Frequent Headaches
☐ Difficulty in opening or closing your mouth
☐ Clenching or grinding your teeth
☐ Periodontal Treatment

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ______________________

Signature of patient, parent or guardian

FAIRLINGTON DENTAL

PATIENT CONSENT/ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Dr. Michael B. Rogers and Dr. Dennis Holly, our dental team, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Privacy Practices. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting our office at (703) 671-1001 and requesting a revised Notice. We will also post any revised notice in our waiting room.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, You may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY. INITIALS ☐

I HAVE REVIEWED, UNDERSTAND SPECIFICALLY (PARAGRAPH 1A) OF THE NOTICE OF PRIVACY.

Signature ____**Date**______________________

Print Name____

PLEASE LIST ANYONE (FAMILY, FRIEND OR OTHER) THAT YOU WOULD LIKE TO HAVE ACCESS TO YOUR INFORMATION:

____

Continued….

Consent of Services

Please initial in each _____ below:

____ **Reserved Appointment Time:** Your appointment time is reserved especially for you. While we understand that certain emergencies may arise, we ask that you provide 3-business days notice for cancellations or changes to your reserved appointment.

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. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

____ **Dental Insurance:** Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will prepare the patients insurance forms in their entirety. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

____ **Medicare Patients:** Our office has **opted out** of Medicare. By signing below, you agree to enter into a private contract with Dr Michael Rogers and Dr Dennis Holly for services rendered. Upon signing below and entering this contract, you agree not to file Medicare for reimbursement or receive reimbursement from Medicare for the services rendered at our office.

____ **Payments:** Payment is expected at the time of service unless prior arrangements have been made. We accept American Express, MasterCard, Visa, Discover, Cash and Checks. We offer a 5% courtesy for any appointments exceeding $1000 when they are prepaid one week prior to the date reserved. We also offer flexible payment arrangements including interest free payments up to a year. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Returned checks will be subject to an additional fee of $30 per return. After a returned check, payment will need to be made with a credit card, cash, money order. No checks can be accepted after a returned item.

I understand that the fee estimates for dental care can only be extended for a period of **one month** from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home, on my cell phone, by email or at my work to discuss matters related to this form.

Dental Benefit Explanation

It is our policy to provide the best dentistry for you. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs and we assume that you are as concerned as we are about maintaining optimal dental health. Our entire team is pleased that you have insurance benefits to help you and your family with the cost of dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so we can work together to ensure these benefits.

Do you accept my insurance? We will gladly help file your insurance for reimbursement each time services are rendered. We are a non-participating office with all plans. As a courtesy, each time services are rendered we will generate a dental claim form, attach the necessary x-rays, narratives and/or photos and ask that you mail it to your insurance company. Your insurance company will process the claim based on the plan your employer has chosen. The payment will be mailed directly to you for reimbursement. Dental insurance is a contract between the employer and the patient. It has no connection at all to us as your dental office. The extent of coverage varies greatly from employer to employer, sometimes even so within a company. It has absolutely nothing to do with the level of service provided by us and the fee charged for our services. An often-misunderstood term used by many insurance companies is “UCR”. This is an arbitrary fee ceiling at which the insurance company will stop reimbursement. These fee ceilings were often set 10-15 years ago. Your employer decides the level of coverage and benefits with your insurance company prior to the time that services are rendered by our office. Please check your plan for waiting periods or specific exclusions. We will be happy to provide dental codes and pricing prior if necessary.

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

____ Date: _____________ Relationship to Patient: _________
Signature of guarantor of payment/responsible party

Please list the name of specialists that you are currently working with or have worked with previously:

Patient's Name: ______________________________

Date: ____________________

Physician: ______________________________

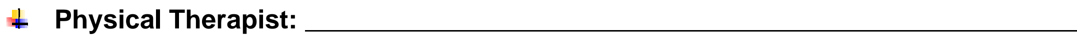
City ____________________ Phone: ____________________

Previous/Current General Dentist: ______________________________

City ____________________ Phone: ____________________

Osteopath: ______________________________

City ____________________ Phone: ____________________



Physical Therapist: ______________________________

City ____________________ Phone: ____________________

Cardiologist: ______________________________

City ____________________ Phone: ____________________

Chiropractor: ______________________________

City ____________________ Phone: ____________________

ENT: ______________________________

City ____________________ Phone: ____________________

Other: ______________________________

Specialty ______________________________

City ____________________ Phone: ____________________

Patient's Name:________________________

Date: ________________________

Sleep Apnea Preliminary Evaluation Form

The only way to be sure if you have obstructive sleep apnea is to have a sleep test either at home from a qualified sleep physician or in a hospital sleep center, but a score of 9 or above on this test is an indication that you should see your doctor.

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?
Choose the most appropriate number for each situation:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Activity	Score
Sitting and Reading	______
Watching TV	______
Sitting, inactive in a public place (theater, meeting, etc.)	______
As a passenger in a car for an hour without a break	______
Lying down to rest in the afternoon when circumstances permit	______
Sitting and talking to someone	______
Sitting quietly after lunch without alcohol	______
In a car, while stopped for a few minutes in traffic	______
Total	______