DENTAL HISTORY

Name: ____
What is the main reason for your visit today? ____
When was your last dental exam? ____
How do you feel about the condition of your mouth? ____
What would you improve? ____
Does the thought of dental care make you nervous? _____ Yes _____ No
If yes, what is most bothersome? ____
Previous Dentist's Name: ____
Why did you leave your former dentist? ____
How often do you:
A. Have dental examinations and cleaning? ____
B. Brush your teeth? ____
C. Floss your teeth? ____
What other dental aids do you use? (Interplak, toothpick, etc.) ____

Are your teeth sensitive to:
Hot or Cold? __ Yes __ No
Sweets? __ Yes __ No
Biting or Chewing? __ Yes __ No

Do You:
Clench or grind your teeth? __ Yes __ No
While asleep or awake? ____________
Bite/chew your lips or cheeks? __ Yes __ No
Hold foreign objects with your teeth? (pen, pipe)` __ Yes __ No
Mouth breathe while asleep or awake? __ Yes __ No
Smoke/chew tobacco? __ Yes __ No
Tend to get cold sores or fever blisters? __ Yes __ No
Experience frequent bad breath or dry mouth? __ Yes __ No
Have difficulty chewing? __ Yes __ No
Experience jaw clicking or popping? __ Yes __ No
Have frequent stress or tension-type headaches? __ Yes __ No

Have you ever had:
Orthodontic treatment? __ Yes __ No
Oral surgery? __ Yes __ No
Periodontal treatment? __ Yes __ No
Bite adjustment? __ Yes __ No
Serious injury to the mouth or head? __ Yes __ No
If yes, please describe: ____________________

Do your gums bleed or hurt? __ Yes __ No
Have your parents experienced gum disease or tooth loss? __ Yes __ No
Have you noticed any loose teeth or a change in your bite? __ Yes __ No
Does food tend to get caught between your teeth? __ Yes __ No
If yes, where? ____________________
Are you satisfied with the appearance of your teeth? __ Yes __ No
Do you expect to keep your teeth all of your life? __ Yes __ No

Have you ever had an upsetting dental experience? __ Yes __ No
If yes, please explain:

____

PATIENT ACQUAINTANCE FORM

Date:			
Patient Name:	M F	I prefer to be called:	
(First, Last, Middle Initial)			
Address:		Birth Date:	SSN:
		Home Phone:	
Email Address:		Work Phone:	
What is the best way to reach you?		Cell Phone:	
Person Responsible for Account			
Name:		Home Phone:	
Address:		Work Phone:	
Emergency Contact			
Name:		Phone:	
Relationship to Patient:			

MEDICAL HISTORY:

- Physician's name: ________________________ City: _______________ Phone: ________________
- Have you taken cortico steroids and/or blood thinners (including aspirin) recently? ____ Yes ____ No
  If yes, please explain: ____
- Are you taking any medication, herbal supplements, or drugs now? ____ Yes ____ No
- If so, please list:____
- Are you sensitive (allergic) to any drugs or anesthetics? ____ Penicillin ____ Aspirin ____ Codeine ____ Sulfa
  ____ Novocaine ____ Other (Please list) ____

Please indicate which of the following you have had or presently have (check all that apply):

- ○ Heart Surgery/Disease/Attack
- ○ Diabetes
- ○ Congenital Heart Disease
- ○ Blood Transfusion
- ○ Heart Murmur
- ○ Asthma
- ○ Sinus Trouble
- ○ Fainting or Dizzy Spells
- ○ Drug or alcohol Abuse
- ○ Nervousness/Anxiety
- ○ Ulcers
- ○ Immunocompromised Disease
- ○ Venereal Disease
- ○ Thyroid Problems
- ○ Mitral Valve Prolapse
- ○ Artificial Heart Valve
- ○ Tuberculosis
- ○ Hay Fever
- ○ Epilepsy or Seizures
- ○ Artificial Joint
- ○ Tumors
- ○ Low Blood Pressure
- ○ Hepatitis A (infectious)
- ○ Hepatitis B (serum)
- ○ High Blood Pressure
- ○ Emphysema
- ○ Hemophilia
- ○ Rheumatic Fever
- ○ Latex Sensitivity
- ○ Radiation Therapy
- ○ Chemotherapy
- ○ Psychiatric Care
- ○ High Cholesterol
- ○ Persistent Cough (3 weeks or longer)
- ○ Weight Loss
- ○ Fever/Night Sweats
- ○ Coughing up Blood
- ○ Chest Pain
- ○ Hoarseness
- ○ Swollen lymph nodes
- ○ Cold Sores/Fever Blisters
- ○ Other _____________

WOMEN: Are you:
Pregnant? ____ Yes ____ No
Nursing? ____ Yes ____ No
Taking Birth Control Pills?
____ Yes ____ No

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered the questions to the best of my knowledge. I understand I am responsible for all cost of dental treatment. I hereby authorize this office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Signature: ________________________________ Date: ___________________________________

SMILE ASSESSMENT FORM

Please consider each statement carefully and circle YES OR NO. The doctor and members of the dental team will discuss your responses with you in confidence.

1. I am concerned about the appearance of my teeth or my smile. Y or N
2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth. Y or N
3. I am concerned about the position or angle of one or more than one of my teeth. Y or N
4. I am concerned about the shape of one or more than one of my teeth. Y or N
5. In social situations, I am sometimes embarrassed by my teeth or my smile. Y or N
6. There are some things about my upper front teeth that I would like to change. Y or N
7. There are some things about my lower front teeth that I would like to change. Y or N
8. I have old fillings or previous dental treatment that is no longer satisfactory to me. Y or N
9. I am missing one or more of my teeth. Y or N
10. I am interested in learning more about esthetic dentistry. Y or N

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank You.

FINANCIAL POLICY

1. Charges for services rendered are due and payable the day of the appointment.
2. **We will assist with filing insurance; however, the patient, parent, or guardian is directly responsible for payment in full of any and all fees not paid for by the insurance company**. There are no exceptions. When treatment *co-pays* are quoted by the office, these are **estimates** only, your actual insurance coverage may be less or more.
3. Personal checks that are returned due to insufficient funds are subject to a $30 service fee.
4. Appointment cancellations with less that 48 hours notice are subject to a fee of $35 per 30 minutes for each appointment scheduled for less than 2 hours, and $200 for appointments scheduled for 2 hours or longer.
5. All accounts over 60 days will be considered past due. Such accounts are subject to 18% APR or 1.5% monthly finance charges. Past due accounts may be referred to an authorized collection agency. Accounts sent to a collection agency will be assessed a $30 collection fee or 33 1/3% collection charge on the unpaid balance, whichever is greater. The patient, parent, or guardian will also be liable for any applicable attorney fees and court costs. Accounts that have been referred to an outside collection agency will be placed on a CASH ONLY basis for any future treatment.
6. We are required by the State of Virginia to keep patient records for three years past the final date of treatment. Records of patients that have not been to this office in over three years may be purged. If you are moving or leaving the practice for any reason you may want to request a copy of your records. There may be a minimal charge to copy your x-rays and records.
7. Payment plans are available only for orthodontic treatment.
8. Amalgams (silver fillings) are no longer used at this office. Most insurance companies do not pay full benefits due to exclusions in individual policies for composite (tooth colored) fillings. The patient, parent, or guardian is liable for all additional costs.

I have read and understand the Financial Policy of Expressions Dental Care. I agree to be responsible for all dental services and materials not paid by my dental insurance for me or my dependents. I authorize release of any information relating to any insurance claims to the relevant insurance company. I authorize payment of dental insurance benefits to Expressions Dental Care, unless payable to me directly per the insurance plan.

__________________________________ ____________________
Signature of Patient/Parent/Guardian if Minor Date

____
Print Name

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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

1. Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly
2. Obtain payment from third-party payers for my health care services
3. Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office 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 of health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

1. Pursuant to Virginia Law 32.1-45.1 – Any patient who exposes a health care provider or his employee/agent to body 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 provider who exposes a patient to body fluid in the above stated manner.

Patient Name: _________________________________ Date: ____________________

Signature: ____________________________________

Relationship to Patient: ____

Dependent family members also covered by this acknowledgement:

For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy due to the following reason:

- The Patient refused to sign
- Communication barriers
- Emergency situation
- Other