Welcome to Leesburg Spa Dentistry!

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

No P.O.Box _____ Home Phone #: _____

_____ Cell Phone #: _____

Age: ____ Sex: _____ Marital Status: _____ Work Phone #: _____

E-mail: _____ (will only be used for office communications)

Please list all the ways you have seen or heard about us?

____Val Pack ____Drove by/Sign ____ Google ____Your Insurance ____ Clipper Flyer in the Mail
___ Sticker on News Paper ____ Belmont News ___ Landsdowne Connection ____ Reflections ____ Zoc Doc
Other:_____

If you were referred to our office by a current patient outside of your immediate family, our CARE TO SHARE program allows you both to earn a $25 credit on both of your accounts!

PRIMARY INSURANCE INFORMATION

Policy Holder: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____

_____ Social Security #: _____

Employer: _____ Phone #: _____

Insurance Co: _____ Phone #: _____

Address: _____ Member ID #: _____

_____ Group #: _____

EMERGENCY CONTACT / RESPONSIBLE PARTY INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Home Phone #: _____

_____ Cell Phone #: _____

Relationship to Patient: _____ Work Phone #: _____

E-mail: _____ (will only be used for office communications)

Is this person currently a patient in our office? _____

PATIENT MEDICAL HISTORY

Primary Care Physician: _____ Phone #: _____ Date of Last Exam: _____

Have you ever been told you have one of the following?

Height: _____
Weight: _____

___ Heart Disease	___ Anemia	___ Asthma	___ Heart Murmur	___ Joint Replacement/Implant
___ Bleeds Easily	___ Swollen Ankles	___ Heart Attack	___ Shortness of Breath	___ Recent Weight Loss
___ Fainting/Seizures	___ AIDS/HIV	___ Arthritis	___ Chest Pain - Angina	___ Psychiatric Treatment
___ Hay Fever/Allergies	___ Emphysema	___ Cancer	___ Epilepsy/Convulsions	___ Radiation Therapy
___ Kidney Disease	___ Rheumatic Fever	___ Diabetes	___ High Blood Pressure	___ Mitral Valve Prolapse
___ Liver Disease:	___ Stomach Ulcer	___ Stroke	___ Low Blood Pressure	___ Sexually Transmitted Disease:
___ Hepatitis	___ Thyroid Disease	___ Glaucoma	___ Leukemia	___ Congenital Heart Defect
___ Jaundice	___ Other: _____			

Do you have any allergies to any medications? _____

YES	NO	
_____	_____	Are you under any medical treatment now? If yes, please explain: _____
_____	_____	Have you ever had any other serious illness not listed above? If yes, please explain: _____
_____	_____	Are you currently taking any medications? If yes, please explain: _____
_____	_____	Have you ever had a bad reaction to local anesthetic or penicillin? If yes, please explain: _____
_____	_____	Do you use tobacco? If yes, please explain: _____
_____	_____	Do you use alcohol, cocaine, or other drugs? If yes, please explain: _____
_____	_____	*For women only:* Are you pregnant or think you may be pregnant? If yes, please explain: _____
_____	_____	*For women only:* If not, are you currently using birth control? _____
_____	_____	Are you on WELL water?

PATIENT DENTAL HISTORY

What is the reason for your visit today? _____

Do you have any pain or discomfort now? Please explain: _____

How many times per day you brush your teeth? _____ Do you floss? How often? _____

Are your teeth sensitive to hot or cold liquids? _____ Or to sweet or sour liquids/foods? _____

Have you ever worn braces? _____ Do you wear Dentures? _____

Have you ever had any trauma to your face or mouth? _____ Do you clench or grind your teeth? _____

Have you ever had prolonged bleeding after extractions? _____ Do you bite your lips or cheeks frequently? _____

Do you have any sores or lumps in or around your mouth? _____ Do you like your smile? _____

Would you like to whiten your teeth? _____ Have you ever had a root canal? _____

Have you ever received oral hygiene instructions for the care of your teeth and gums? _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. I authorize and request my insurance company to pay directly to Elite Smiles Dental any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and Elite Smiles Dental has no leverage on assuring that my claims will be paid as estimated. As a courtesy to their patients, Elite Smiles Dental completes and files my insurance claims for me. I understand that I am responsible for any unpaid or denied claims. *Thank you for understanding that as your dental care provider, our relationship is with you and not with your insurance company.*

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 health practitioners. I understand that Elite Smiles Dental complies with all HIPAA policies and regulations and that I may request a detailed outline of such policies.

_____ _____ _____

(Please Print) Name of Patient | Signature of Patient/Parent or Guardian | Today's Date

_____

Signature of Treating Dentist

FINANCIAL POLICY

Thank you for choosing Elite Smiles Dental as your dental care provider. Our office is committed to providing you with the highest quality dental care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. We do provide many payment options to accommodate our patient's needs. ***Please discuss your options with our staff to find the solution that is best for you.***

Payment Options:

I have Dental Insurance/Or in the future when you do:

Your insurance policy is a contract between you and your insurance company. We are not a part of the contract. In the event we do accept assignment of benefits or your insurance company has not paid your account in full within 60 days, **the balance will be your responsibility**. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the highest quality dental treatment for our patients and we charge what is the usual and customary for our area. ***You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.*** Your complete insurance information must 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.

As a courtesy to all patients we will verify your dental insurance benefits, ***but you are responsible to know your plan coverage, exclusions and limitations.*** The estimated amount not covered by your insurance is due the day you reserve time with the doctor and may be paid by cash or credit card. We also offer extended payment plans upon qualification. ***All estimates are subject to final approval by your dental insurance plan, therefore the amount due is subject to change after final review by your insurance company.***

_____Initial

INITIAL PAYMENT FOR DENTAL TREATMENT: Most plans cover routine clinical exams and cleaning without requiring a deductible for diagnostic or preventative treatment; however, some plans do require a co-payment for x-rays and dental exams. Deductibles (payment due by the patient) are customarily charged for some procedures including, but not limited to: fillings, crowns, extraction, root canal therapy and periodontal treatment. Co-payments and deductibles are due prior to any service being performed.

_____Initial

BOOKING TREATMENT WITH NON SEDATION: In order to reserve a time with our Doctors, we do require half payment down of treatment scheduled. On the day of your reserved time you are required to pay the other half. We do this to insure all patients are able to receive their treatment in a timely manner. _____Initial

RESIN-BASED COMPOSITE RESTORATIONS (Fillings): Most dental insurance plans do not allow full benefits for composites (white fillings) performed on posterior teeth (back molars). The plan benefit will customarily pay for less expensive treatment called an Amalgam (silver/mercury based). In an effort to provide our patients the highest level of modern dental care, we do not do Amalgams, rather only composite fillings.

PULP-CAP TREATMENT (medication to protect the pulp chamber): Most dental plans do not allow additional benefits for pulp-cap treatment (the procedure in which the filling is very deep and the nearly exposed pulp is covered with a protective medication to help with healing and repair via formation of secondary dentin). At Elite Smiles Dental we do this treatment when medically indicated to provide the highest level of dental care for our patients. If your insurance does not cover the charges or does not allow a separate charge, you will be responsible for payment for this service. _____Initial

MISSED APPOINTMENT FEE: Elite Smiles Dental does charge a missed appointment fee of $50 per half hour of appointment time for all appointments not given at least two business days (48hrs) advance notice. Please call us immediately once you realize that you cannot keep your appointment. _____Initial

CHARGES: All returned checks are subject to a $35 fee. All balances over 30 days are subject to interest in the amount of 1.5% per month. We reserve the right to apply a $25 late charge fee for any overdue payments for each month that the balance goes unpaid. We will report your overdue balance to any credit reporting agency or credit bureau that we choose. _____Initial

PAST DUE AMOUNTS: Any accounts over 90 days past due will be turned over to a collection agency or attorney; you agree to pay all fees including but not limited to attorney fees, court costs and collection agency fees. With past due balances all family members in the family's file are held responsible. If one person in the chart has a credit we may use that credit to pay off the balance owed to the office.

_____Initial

TRANSFERRING RECORDS: Elite Smiles Dental requires you to sign our Records Release Form when requesting records. We require at least 48 hours to complete the transfer as requested. We require at least three (3) business days if your record is more than two years old and stored in the company archive. The processing fees are $25.00 per record. The fee is waived if we are referring you to a specialist. _____Initial

Thank you for understanding our Financial Policy. I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY. ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I AGREE TO ABIDE BY THIS FINANCIAL POLICY.

(Please Print) Name of Patient	Signature of Patient / Parent or Guardian	Today's Date

Please Handle Me With Care...

Patient's Name: _____

What is most important to you about your overall health?

What is important to you in relationship with your healthcare provider?

Please CIRCLE the number next to the statements that concern you or describe your situation:

1. I have not been to the dentist for a long time, and I feel worried about what you will say about my teeth and my oral hygiene.
2. My teeth are very sensitive.
3. Pain relief is a top priority for me.
4. I'm very anxious about injections.
5. I feel out of control in the dental chair (or I have an extreme problem with lying down).
6. I gag easily.
7. I hate the noise of dental instruments.
8. I hate the sight and/or smell of a dental office.
9. I have a preference for male or female dentist:
10. Please tell me about the treatment options and the ways these can be carried out.
11. I need to know that you will stop when I give a pre-agreed "stop" signal during treatment.
12. It would help me if you could explain to me what you are doing and why.
13. I have health problems that we need to discuss.
14. I am feeling more stress and anxiety in my life now, than in the past.
15. There are other issues I'd like to talk about that aren't covered on this form:
16. What special things can we do in our office to make sure you are well cared for?