WELCOME TO FAIRFAX DENTAL ESTHETICS, PLLC

WE'D LIKE TO GET TO KNOW YOU BETTER! THESE FILES ARE CONFIDENTIAL

REGISTRATION INFORMATION

Name____ Today's Date________________

Home Address____City_____________State____ Zip________

Home Phone_________________________ Date of Birth_________________ Age_______ Sex- M F

Business Phone________________________ Employed by_____________________________________

Cell Phone___________________________ E-mail____

Occupation____________________________________ SSN____________________________________

Business Address________________________________City______________Zip__________________

Marital Status - ___ Married ___Single ___Divorced ___Separated ___Widowed

If other than above, who will be responsible
for this account?(relationship)____

Physician (name, phone, location) ____

In case of emergency, contact ____

How did you hear about our office? (Referred by)____

Date of last dental visit____

Purpose of today's visit. Remarks: ____

FINANCIAL INFORMATION

Fees are due and payable upon completion of each visit unless other written arrangements are made in advance. We accept cash, Checks, Visa, AMEX, Discover and MasterCard. If you have dental insurance, we will process and submit an initial standard insurance claim form for you as a courtesy. Please provide us with complete and accurate information. If you have insurance, or you are a member of a PPO Dental plan, the co-payments or reduced fee will be accepted only if your insurance eligibility is confirmed in advance of treatment. All fees are estimates only. Final fees are subject to change and insurance company terms and conditions. It is your responsibility that all fees be paid.

Name of insurance company (primary)________________________ Policy #____________ Group #_______________

Name of subscriber (policy holder) ______________________ Date of Birth______________ SSN_________________

Visa/MC/AMEX Card# ____________________________________ Exp. Date___________ Ins Co.#______________

Charges that will be made to you may include:
$10 per month for accounts over 30 days past due. For any returned checks, there will be a $50.00 fee.

$50 per broken appointment unless 48 hours notice is given

$50 for X-ray or record duplication.

Please feel free to discuss your dental treatment and financial concerns.

I hereby understand and grant authority to administer treatment or anesthetics and to perform such operations or procedures as may be deemed necessary or advisable in my diagnosis and treatment. Registration, and medical and dental questions have been understood and answered to the best of my ability and knowledge. I further accept the financial obligations of my, or my dependent's treatment.

Patient or Guardian Signature ____________________________________ Date___________________________

Name: ______________________________________ Date: ___________________

Medical and Dental History

We ask the following medical and dental history questions to insure safe treatment. Please, indicate your response to each question with a check mark. If you are unsure of the answer, leave the blank. Keep us informed of any changes in your health.

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Yes No

___|___ Are you in good health?
___|___ Do you take any medicine, pills, drugs?(**list**)
____
____
____
___|___Are currently under treatment by a physician?
(**please explain**)_____________________________
____
___|___Have you ever had an unusual reaction or are you allergic to any medication (Penicillin, Codeine, Novocain, Aspirin)? List______________________
____
___|___ Are you allergic to any food? (**list**)
____
___|___ A serious illness or major operation?
___|___ Trouble walking, sitting or lying down?
___|___ High Cholesterol?
___|___ Do you have high or low blood pressure?
___|___ Any bleeding problem or on blood thinner?
___|___ Anemia?
___|___ Rheumatic Fever?
___|___ Heart Murmur or Heart Valve Defect?
___|___ Heart Diseases?
___|___ Frequent Headaches?
___|___ Epilepsy?
___|___ Circulation problems?
___|___ Hepatitis, jaundice or liver disease? (**circle one**)
___|___ Tuberculosis or lung disease? (**circle one**)
___|___ Asthma, hay fever, sinus trouble?(**circle one**)
___|___ Stomach trouble , ulcers? (**circle one**)
___|___ Kidney Disease?
___|___ Diabetes?
___|___ Do you require medication prior dental treatment? (antibiotics)
___|___ Thyroid Disease?

Yes No

___|___ Cancer? **List**________________________________
___|___ Any Tumor or Growth? (**circle one**)
___|___ Blood Disorder or AIDS? (**circle one**)
___|___ X-Ray treatments?
___|___ Glaucoma or eye trouble?
___|___ Do you wear contacts or glasses?
___|___ Trouble hearing?
___|___ Nervous problems?
___|___ Mental illness?
___|___ Do you smoke?
___|___ Sexually transmitted disease? **List**______________
___|___ (Women) Are you pregnant?
___|___ Are you on a diet?
___|___Do you exercise regularly?
___|___ Are you bothered with tooth sensitivity? (cold, Pressure?) _________________________
___|___ Do you have any problems eating or swallowing?
___|___ Do your gums bleed when brushing or flossing?
___|___ Have you ever had any injury to your face or jaw?
___|___ Do you grind or clench your teeth?
___|___ Does your jaw ever get "out-of-joint" clicks or pop?
___|___ Are you aware of any swelling, rushes, lumps, white patches in your mouth?
___|___ Are you unhappy with your smile or teeth color?
___|___ Do you have breath problems or mouth odors?
___|___ Do you fear dental treatment?
___|___ Have you ever had braces, orthodontics?
___|___ Root canal therapy?
___|___ Gum treatment?
___|___ Nitrous Oxide (laughing gas)?
___|___Been put to sleep for dental treatment?
___|___ Any unusual dental experience? (**please explain**)
____
____

Preferred Pharmacy________________________________ Phone____

Please add additional information about your medical or dental health, past or present that might aid in your treatment ____

Written Financial Policy

Thank you for choosing Fairfax Dental Esthetics, PLLC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard or Discover Card
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Fairfax Dental Esthetics requires payment prior to the completion of your treatment.

For plans requiring more than 2 appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. Insurance is a contract between you and your insurance company. We are NOT party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, but it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion and/or the charges for services rendered but not covered and/or not paid (denied) by your insurance. You must inform us if you lose or about to lose your coverage.[2]

A fee of $50 is charged for patients who miss or cancel without 48-hour notice.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I, ____ Date _______________________ do hereby consent and acknowledge my agreement to the terms set forth in the WRITTEN FINANCIAL POLICY FORM and any subsequent changes in the office policy after giving patient consent. I understand that this consent shall remain in force from this time forward.

9621 Fairfax Blvd, Fairfax, VA 22031
P: (703) 279-3400 F: (703)272-7726
E-Mail: fairfaxdentalesthetics@gmail.com

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[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1-Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2-It is the policy of this office to remind patients of their appointments. We may do this be telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to the office policy and new technology that you might find valuable or informative.

3-The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4-You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurances payers in normal performance of their duties.

5-You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6-Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7-We agree to provide patients with access to their records in accordance with state and federal laws.

8-We may change, add delete or modify any of these provisions to better serve the needs of both the practice and the patient after giving patient notice.

9-You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to confirm to your request.

I, ____ date _______________________ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in the office policy. I understand that this consent shall remain in force from this time forward.

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Media Release

We at Fairfax Dental Esthetics understand that choosing a new dentist and a dental health team can be challenging. Let us welcome you and share some insights about what we do for our patients at Fairfax Dental Esthetics.

"Our purpose is to help people achieve the highest level of well-being appropriate for them and, in so doing, to transform the quality of their lives."

In other words, we help you be or become as healthy as you choose. This is a major departure from the way we were trained. Instead of telling you how healthy you ought to be, we will try to help you understand your choices about dental health and then let you make a free and informed decision. In order to do this, we take photographs as a part of your new patient exam. These photographs are used to:

- Discuss your treatment needs and wants
- Discuss treatment options with specialists
- Help with insurance claims
- OTHER

I hereby consent for Fairfax Dental Esthetics to use, reproduce, exhibit or distribute (in full or in part) any photographic, video, film and or audio recording made of me or my likeness; and/or any written extraction of such recordings in which I may be included, for any purpose whatsoever, in and in any all media now or hereafter know for illustration promotion, art, editorial, advertising, trade, or any other purpose whatsoever. I also consent to the use of any printed matter in conjunction therewith. I hereby waive any right that I may have to inspect or approve the finished product or products and the advertising copy or the other matter that may be used in connection therewith or the use to which it may be applied.

I hereby release, discharge and agree to hold harmless Fairfax Dental Esthetics and Dr. Sanae Berrada D.D.S., Dr.Sandra Glikman D.D.S., and Dr.Aya Jawad D.D.S. and all persons acting under its permission or authority from any liability or injury that may occur while performing or appearing in the said video, audio, or photographic production.

Patient Name (print) ____________________________________

Patient Signature _______________________________________ Date ____________________

Address: ____

City: ________________________ State: _____________________ Zip: _____________________

Email: ____

Phone: ____

Guardian Signature (if under 18): ____

Sleep Apnea Survey

- Do you snore loudly (louder than talking or louder enough to be heard through closed doors)? **YES / NO**
- Do you often feel tired, fatigue, or sleepy during the day? **YES / NO**
- Has anyone observed you stop breathing during your sleep? **YES / NO**
- Do you have or are you being treated for high blood pressure? **YES / NO**
- BMI (Body Mass Index) more than 35? **YES / NO**
- Age over 50 years old? **YES / NO**
- Neck circumference >15.75 inches? **YES / NO**
- Gender? **MALE / FEMALE**

Body Mass Index (BMI) Table for Adults

Obese (>30) | Overweight (25-30) | Normal (18.5-25) | Underweight (<18.5)

HEIGHT in feet/inches and centimeters

WEIGHT		4'8"	4'9"	4'10"	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"	6'5"
lbs	(kg)	142cm		147	150	152	155	157	160	163	165	168	170	173	175	178	180	183	185	188	191	193	196
260	**(117.9)**	**58**	**56**	**54**	**53**	**51**	**49**	**48**	**46**	**45**	**43**	**42**	**41**	**40**	**38**	**37**	**36**	**35**	**34**	**33**	**32**	**32**	**31**
255	(115.7)	57	55	53	51	50	48	47	45	44	42	41	40	39	38	37	36	35	34	33	32	31	30
250	**(113.4)**	**56**	**54**	**52**	**50**	**49**	**47**	**46**	**44**	**43**	**42**	**40**	**39**	**38**	**37**	**36**	**35**	**34**	**33**	**32**	**31**	**30**	**30**
245	(111.1)	55	53	51	49	48	46	45	43	42	41	40	38	37	36	35	34	33	32	31	31	30	29
240	**(108.9)**	**54**	**52**	**50**	**48**	**47**	**45**	**44**	**43**	**41**	**40**	**39**	**38**	**36**	**35**	**34**	**33**	**33**	**32**	**31**	**30**	**29**	**28**
235	(106.6)	53	51	49	47	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30	29	29	28
230	**(104.3)**	**52**	**50**	**48**	**46**	**45**	**43**	**42**	**41**	**39**	**38**	**37**	**36**	**35**	**34**	**33**	**32**	**31**	**30**	**30**	**29**	**28**	**27**
225	(102.1)	50	49	47	45	44	43	41	40	39	37	36	35	34	33	32	31	31	30	29	28	27	27
220	**(99.8)**	**49**	**48**	**46**	**44**	**43**	**42**	**40**	**39**	**38**	**37**	**36**	**34**	**33**	**32**	**32**	**31**	**30**	**29**	**28**	**27**	**27**	**26**
215	(97.5)	48	47	45	43	42	41	39	38	37	36	35	34	33	32	31	30	29	28	28	27	26	25
210	**(95.3)**	**47**	**45**	**44**	**42**	**41**	**40**	**38**	**37**	**36**	**35**	**34**	**33**	**32**	**31**	**30**	**29**	**28**	**28**	**27**	**26**	**26**	**25**
205	(93.0)	46	44	43	41	40	39	37	36	35	34	33	32	31	30	29	29	28	27	26	26	25	24
200	**(90.7)**	**45**	**43**	**42**	**40**	**39**	**38**	**37**	**35**	**34**	**33**	**32**	**31**	**30**	**30**	**29**	**28**	**27**	**26**	**26**	**25**	**24**	**24**
195	(88.5)	44	42	41	39	38	37	36	35	33	32	31	31	30	29	28	27	26	26	25	24	24	23
190	**(86.2)**	**43**	**41**	**40**	**38**	**37**	**36**	**35**	**34**	**33**	**32**	**31**	**30**	**29**	**28**	**27**	**26**	**26**	**25**	**24**	**24**	**23**	**23**
185	(83.9)	41	40	39	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23	22
180	**(81.6)**	**40**	**39**	**38**	**36**	**35**	**34**	**33**	**32**	**31**	**30**	**29**	**28**	**27**	**27**	**26**	**25**	**24**	**24**	**23**	**22**	**22**	**21**
175	(79.4)	39	38	37	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21
170	**(77.1)**	**38**	**37**	**36**	**34**	**33**	**32**	**31**	**30**	**29**	**28**	**27**	**27**	**26**	**25**	**24**	**24**	**23**	**22**	**22**	**21**	**21**	**20**
165	(74.8)	37	36	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21	20	20
160	**(72.6)**	**36**	**35**	**33**	**32**	**31**	**30**	**29**	**28**	**27**	**27**	**26**	**25**	**24**	**24**	**23**	**22**	**22**	**21**	**21**	**20**	**19**	**19**
155	(70.3)	35	34	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	20	20	19	19	18
150	**(68.0)**	**34**	**32**	**31**	**30**	**29**	**28**	**27**	**27**	**26**	**25**	**24**	**23**	**23**	**22**	**22**	**21**	**20**	**20**	**19**	**19**	**18**	**18**
145	(65.8)	33	31	30	29	28	27	27	26	25	24	23	23	22	21	21	20	20	19	19	18	18	17
140	**(63.5)**	**31**	**30**	**29**	**28**	**27**	**26**	**26**	**25**	**24**	**23**	**23**	**22**	**21**	**21**	**20**	**20**	**19**	**18**	**18**	**17**	**17**	**17**
135	(61.2)	30	29	28	27	26	26	25	24	23	22	22	21	21	20	19	19	18	18	17	17	16	16
130	**(59.0)**	**29**	**28**	**27**	**26**	**25**	**25**	**24**	**23**	**22**	**22**	**21**	**20**	**20**	**19**	**19**	**18**	**18**	**17**	**17**	**16**	**16**	**15**
125	(56.7)	28	27	26	25	24	24	23	22	21	21	20	20	19	18	18	17	17	16	16	16	15	15
120	**(54.4)**	**27**	**26**	**25**	**24**	**23**	**23**	**22**	**21**	**21**	**20**	**19**	**19**	**18**	**18**	**17**	**17**	**16**	**16**	**15**	**15**	**15**	**14**
115	(52.2)	26	25	24	23	22	22	21	20	20	19	19	18	17	17	16	16	16	15	15	14	14	14
110	**(49.9)**	**25**	**24**	**23**	**22**	**21**	**21**	**20**	**19**	**19**	**18**	**18**	**17**	**17**	**16**	**16**	**15**	**15**	**15**	**14**	**14**	**13**	**13**
105	(47.6)	24	23	22	21	21	20	19	19	18	17	17	16	16	16	15	15	14	14	13	13	13	12
100	**(45.4)**	**22**	**22**	**21**	**20**	**20**	**19**	**18**	**18**	**17**	**17**	**16**	**16**	**15**	**15**	**14**	**14**	**14**	**13**	**13**	**12**	**12**	**12**
95	(43.1)	21	21	20	19	19	18	17	17	16	16	15	15	14	14	14	13	13	13	12	12	12	11
90	**(40.8)**	**20**	**19**	**19**	**18**	**18**	**17**	**16**	**16**	**15**	**15**	**15**	**14**	**14**	**13**	**13**	**13**	**12**	**12**	**12**	**11**	**11**	**11**
85	(38.6)	19	18	18	17	17	16	16	15	15	14	14	13	13	13	12	12	12	11	11	11	10	10
80	**(36.3)**	**18**	**17**	**17**	**16**	**16**	**15**	**15**	**14**	**14**	**13**	**13**	**13**	**12**	**12**	**11**	**11**	**11**	**11**	**10**	**10**	**10**	**9**

3 or More YES answer: **High-risk** for OSA

Less than 3 YES answer: **Low-risk** for OSA

*Sleep Apnea: A potentially serious sleep disorder in which breathing repeatedly stops and starts

*OSA (Obstructive Sleep Apnea)