LOWES ISLAND DENTISTRY

CONFIDENTIAL PATIENT REGISTRATION

PATIENT'S NAME

Last_____First_____Middle____ SSN _ _ _-_ _- _ _ _ _
Street_____apt#_____
City _____State_____Zip_____
Home Phone _____ Cell Phone_____
Work Phone _____ Email _____

Name you prefer to be called by_____SEX: M F Birthdate_____
Who may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION (if not the patient)

Last_____First_____Middle_____
Relationship to Patient _____ Soc. sec# _ _ _-_ _-_ _ _ _SEX: M F
Birthdate ___/___/___ADDRESS: Street_____apt#_____
City _____State_____Zip_____
Home Phone _____ Cell Phone_____
Work Phone _____ Email _____

DENTAL INSURANCE INFORMATION

Insured's Name _____Insured'sBirthdate ___/____/___
Soc. Sec. #_ _ _- _ _- _ _ _ _Insurance Company _____
Insured's Employer_____Subscriber#_____

EMERGENCY CONTACT INFORMATION

Name _____
Phone_____
Email_____

A MINIMUM FEE OF $100 MAY BE ASSESSED FOR A CANCELLATION OF LESS THAN 48 HOUR

Uzma S Ansari DMD, FAGD
20789 Great Falls Plaza, Suite 104, Potomac Falls, VA 20789
www.lowesislanddentistry.com

LOWES ISLAND DENTISTRY

DENTAL HISTORY

Previous Dentist_____ How long have you been a patient? _____
How would you rate the condition of your mouth? ( ) EXCELLENT ( ) GOOD ( ) FAIR ( ) POOR
Date of most recent dental exam? _____ Date of most recent x-rays? _____
I routinely see my dentist every: ( ) 3 MO ( ) 4 MO ( ) 6 MO ( ) 12 MO ( ) Not Routinely
WHAT IS YOUR IMMEDIATE CONCERN? _____

In order for us to provide you with an exceptional quality of care, we would like to get to know you better. As providers all of the following are important to us however we would like to know which is the most important to you?

a. Cosmetic
b. Function
c. Comfort
d. Longevity

When considering having treatment done, which of these would be of concern to you?

Fear
Time
No Trust
Budget
No Sense of Urgency

What is the **most important quality** for you in a relationship with a Doctor?

_____

Are you the type of person who likes a lot of **detailed information** or do you prefer more **bottom line information**? (circle one please)

HEALTH HISTORY

Name _____Preferred Name_____Age_____
Name of Physician_____Date of last health care exam: _____
What was this exam for?_____
What is your estimate of your general health? O Excellent O Good O Fair O Poor

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Hospitalization for illness or injury_____	No	Yes			
Blood Disorders?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma, COPD or other Lung Diseases	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph	No	Yes

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			Nodes		
Diabetes	No	Yes	Psychiatric Therapy	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Renal Dialysis	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial)or Heart Transplant or Heart Murmur	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery, Angina	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA?	No	Yes
If so, when did the treatment begin?			When did the treatment end?	No	Yes

Please list any medications you are currently taking and dosages:_____

_____

Please list any dietary or herbal supplements you are taking, and for what purpose:

_____

Women: Are you pregnant? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics or epinephrine……... No Yes
b. Penicillin or other antibiotics …… No Yes
c. Fluoride…… No Yes
d. Aspirin, Ibuprofen or Tylenol …..…… No Yes
e. Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives…… No Yes
f. Latex or Metals
g. Other (please specify)_____

Do you use tobacco?	No	Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (Print Name) *Patient Signature* *Date*

_____ _____

Doctor Signature *Date*

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MEDIA RELEASE

We at Lowes Island Dentistry 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 Lowes Island Dentistry.

"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 Lowes Island Dentistry 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 and all media now or hereafter known 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 used in connection therewith or the use to which it may be applied.

I hereby release, discharge and agree to hold harmless Lowes Island Dentistry and Dr Uzma S Ansari, DMD, FAGD 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.

Name (print): _____
Signature:_____
Address:_____
City : _____ **State:** _____ **Zip:** _____
Email: _____
Phone: _____
Guardian (if under 18): _____

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnosis, treatment, and applying for future care of treatment. It also includes billing documents for those services.

Your Health Information Rights
The health and billing records we maintain are the physical property of Dr Ansari's office. You have the following rights with respect to your Protected Health Information.

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office-we are not required to grant the request but we will comply with any request granted.
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office.
3. Right to inspect and copy your health record and billing record. You may exercise this right by delivering the request in writing to our office using the form we provide you upon request. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. If you request copies, we may charge a small fee. If you request an alternative format, we will charge a cost based fee for providing your health information in that format.
4. Right to appeal a denial of access to your protected health information, except in certain circumstances.
5. You have the right to request that we amend your protected health information. (Your request must be in writing, and it must explain why information should be amended). Dr Ansari is not required to make such amendments. You may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
6. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.
7. Right to confidential communication by requesting that communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide you upon request. If you want to exercise any of the above rights, please contact the office manager at Lowes Island Dentistry, 703-444-4441. 20789 Great Falls Plaza, Suite 104, Potomac Falls, VA 20165, in person or in writing.

Our Responsibilities
Our office is required to: * Maintain the privacy of your health information as required by law.
* Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.
* Abide by the terms of this Notice.
* Accommodate your reasonable requests regarding methods to communicate health information with you.
* Accommodate your request for an accounting of disclosures.
We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice", by visiting our office and picking up a copy, or by downloading the revised copy from our website at www.lowesislanddentistry.com.

To Request Information or File a Complaint
If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the Office Manager at 703-444-4441, 20789 Great Falls Plaza, Suite 104, Potomac Falls, VA 20165. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Office Manager. You also may submit a written complaint to the U.S. Department of Health and Human Services. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from this office. We cannot, and will not retaliate against you for filing a complaint with the Secretary of Health and Human Services.

LOWES ISLAND DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this agreement.

I have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

O Individual refused to sign

O Communication barriers prohibited obtaining the acknowledgement

O An emergency situation prevented us from obtaining acknowledgement

O Other (please specify)

_____

_____

_____

_____

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OUR THREE COMMITMENTS

A commitment between two people builds trust. I have three important commitments in my practice. I have put them in writing because I live by them. I realize that the institution of these three commitments may be different from what you may have been accustomed to in other dental practices; however, I believe that these commitments are necessary in building the trust that it takes for you and I to successfully work together.

COMMITMENT TO TREATMENT

Dental Disease is nearly 100% preventable. Therefore, I believe that all treatment begun should be completed. I will deliver the best dental care that I am capable of delivering and I ask that you care for your dental health on a daily basis. Incomplete treatment leads to unnecessary problems and complications, such as the loss of teeth. It also leads to more advanced disease which unnecessarily adds to your cost and can lead to a breakdown in communication between the two of us. I know that you want as little dentistry done in your lifetime as possible.
"Our purpose is to help people achieve the highest level of well-being appropriate for them and, in so doing, to enhance 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. Help yourself achieve that by following through with your plan.

COMMITMENT TO APPOINTMENT

I will reserve time for you and give you my utmost attention and care and will rarely keep you waiting. An appointment scheduled in my office is a bond of trust that my team and I will be here to serve you and that you will be on time and prepared for your appointment.

COMMITMENT TO FINANCIAL CONSIDERATIONS

I believe that I have a responsibility to use my best professional care, skill, and judgment in helping you achieve your dental health goals. As I have stated above, I believe dental disease is nearly 100% preventable. I will deliver the best dental care that I am capable of delivering to help you attain your goals. It is up to you to pay for it as we agree to on your Financial Commitment Form.

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Financial Agreement for Patients

Insured Patients

Our office understands the value of having insurance benefits to use toward your dental treatment, and we are happy to assist you by courtesy filing the necessary electronic forms and supporting documents as needed to obtain payment. We ask that you provide our business team with a benefit card or any other identifying paperwork as well as the policy holder subscriber ID and birthdate. In the event of any coverage changes we appreciate notice in advance of any dental services. Most patients understand there is never a guarantee of coverage and the benefit allowable is determined at the time the claim is received and processed with your insurance company. The insurance coverage that you have is a contract between you/your employer and the insurance company therefore in the event on non-payment you as the patient are always ultimately responsible for payment of services rendered despite insurance denial. In the unlikely event that any insurance claims remain unpaid over 60 days, the claim will be closed and you will be responsible for paying our office and requesting direct insurance reimbursement.

Payment

Our office will present any out pocket dental expenses before any work is performed. Any services non-covered, copayments or non-insured will be expected to be paid in full at the time services are rendered, we do not issue billing unless there is an uncollected balance once insurance has paid your claim. We offer patient care financing with Care Credit and an in-house dental discount plan. Our knowledgeable business team will be happy to give you information if needed about each of these options. We accept Cash, Private Checks, Visa, Amex, MC and Care Credit as form of payment for services.

Workers Comp/Third Party and Divorce Situation Patients

Our office does not participate in third party billing of any kind. In this event or circumstance we will be happy to provide an insurance claim and any needed documentation for you to file privately for direct reimbursement, we will collect payment from the patient in full at the time of service. In the event of a separation or divorce, we ask that all applicable co-payments are paid by the parent or guardian that accompanies the minor to their dental appointment at the time of service. If insurance benefits are to be filed on behalf a child or minor, please provide the necessary filing information to our business team.

Cancellation Fee

Our office requires 48 hour notice in the event of cancellation or reschedule. We understand emergency happens however we are a business that respects our patient's time and we ask the same from our patients. A fee of $100 per hour scheduled will be applied to your account in the event of repeated missed appointments.

Collection

As stated above, our office will work to make you aware of any out of pocket cost however any accounts that involve insurance are an estimate until the claim is considered and paid. Our office will issue a statement and work to communicate with you in the event of a past due balance, it is your responsibility to ensure payment is received in a timely manner. Accounts over 90 days past due without response will be issued a $50 collection fee and the account will be transferred to an outside collection agency for further pursuit of the debt.

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I understand my financial obligation as outlined above. I am aware that any insurance related balance outstanding after 60 days is my responsibility to pay. I will provide any updated insurance changes to Lowes Island Dentistry for billing purposes and I am ultimately and financially responsible for any and all services rendered to me.

_____	_____	_____
Print Patient Name	**Signature/Guardian**	**Date**

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