nalasmiles

901 N Washington St., Suite 202
Alexandria, VA 22314
t. 7037069564 | w. www.nalasmiles.com

Patient Information

Name: _____ Birth Date: _____ Age: _____ Sex ❑ M ❑ F

Street address: _____ City: _____ State: _____ Zip: _____

Soc. Sec #: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____ Marital Status: _____

Employer: _____ Occupation: _____

How did you hear about our practice? _____

Emergency Contact _____ Relation to Patient _____ Phone _____

Responsible Party Information

❑ **Check here for Self**

Name _____ Birth Date _____

Relation to Patient _____ Phone _____ Soc. Sec. # _____

Address (if different from patient's) _____

Employer _____ Occupation _____ Work Phone _____

Insurance Information

Policy Holder's Name _____ Relation to Patient _____ Birth Date _____

Insurance Company Name _____ Policy Holder's Employer's Name: _____

Soc. Sec. # _____ Subscriber # _____ Cell Phone _____

Do you have secondary insurance? ❑ Yes ❑ No

Medical History

Do you have any general health problems? ❑ Yes ❑ No Please specify _____

Are you currently under physician's care? ❑ Yes ❑ No

Name and phone # of physician _____

Are you currently taking any drugs or medications? ❑ Yes ❑ No Please list _____

Are you allergic to: ❑ Penicillin ❑ Codeine ❑ Latex ❑ Other

Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Check X if you have or have had any of the following:

❑ Anemia	❑ Blood Disorders	❑ Epilepsy	❑ Prolonged Bleeding
❑ Cortisone Treatments	❑ Cancer	❑ Heart Murmur	❑ Radiation Treatment
❑ Hepatitis	❑ Chemical Dependency	❑ Heart Problems	❑ Respiratory Disease
❑ Arthritis/Rheumatism	❑ Chemotherapy	❑ HIV/AIDS	❑ Rheumatic Fever
❑ Artificial Heart Valves	❑ Scarlet Fever	❑ Kidney Disease	❑ Shortness of Breath
❑ Artificial Joints	❑ Healing complications	❑ Liver Disease	❑ Stroke
❑ Asthma	❑ Diabetes	❑ Mitral Valve Prolapse	❑ Thyroid Problems
❑ High Blood Pressure		❑ Pacemaker	❑ Tuberculosis

Signature Of Patient/Legal Guardian _____ **Date** _____

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Dental History

- What prompted you to seek dental care at this time? _____
- Has the fear of discomfort kept you from regular dental visits?..... ❑ Yes ❑ No
- When was your last dental appointment? _____
- How long since your last thorough examination with full mouth x-rays? _____
- Are your teeth sensitive to:
  Heat? ❑ Yes ❑ No **Cold?** ❑ Yes ❑ No **Sweets?** ❑ Yes ❑ No **Biting Pressure?** ❑ Yes ❑ No
- Does food constantly get stuck between certain teeth in your mouth?..... ❑ Yes ❑ No
- Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc. ❑ Yes ❑ No
- Do your gums bleed while brushing?..... ❑ Yes ❑ No
- Do you ever avoid any part of the mouth while brushing?..... ❑ Yes ❑ No
- Have you been instructed regarding proper home care? ..... ❑ Yes ❑ No
- Do you have an unpleasant taste or odor in your mouth? ..... ❑ Yes ❑ No
- Do you smoke?..... ❑ Yes ❑ No
- Do you frequently snack between meals on sweets or chew gum?..... ❑ Yes ❑ No
- How often do you brush your teeth? _____
- How often do you floss? _____

Remarks

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

***You may refuse to sign this acknowledgement & authorization. In refusing we <u>may not be allowed</u> to process your* insurance claims.**

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO <u>CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION</u> VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE <u>INFORMATION ABOUT MY HEALTH</u> BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ Any of the Above

I APPROVE BEING CONTACTED ABOUT <u>SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO</u> on behalf of Mosaic Smiles via:

□ Phone Message
□ Text Message
□ Email
☐ None of the above (opt out)

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

_____ _____ **Date:** _____
Printed name of Patient **Signature of Patient / Guardian of Patient**

_____ _____ **Date:** _____
Guardian / Legal Representative **Signature of Patient / Guardian of Patient**

<u>Office Use Only</u>
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) ___ _____

Signature of Privacy Officer (Office Personnel)

Financial Policy

Welcome! Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our Financial Policy. If you have any questions after reviewing our policy, please ask the receptionist.

Insurance*:* If you have dental insurance, we will gladly file your claim for you; however, you are responsible for your account. Insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing your benefits. Any amount that is not covered by your insurance is your financial responsibility.

Payment Options: In addition to Cash, Checks, Visa, MasterCard, Discover, and American Express we offer payment options-please see our financial coordinator for details. If payment is made with a check, and it is returned, you will be responsible for a $35.00 returned check charge.

Payment is due at the time of service. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.

If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. If your account becomes delinquent, it will be turned over to a local collection agency and you will incur any collection costs and any related attorney's fees.

We request **48 hour notice** if you are canceling an appointment. **If no attempt is made a $50.00 cancellation fee will be assessed to your account.**

Patient or Guardian Signature:_____**Date:**____/____/_____

Printed Name of Patient or Guardian:_____