PATIENT MEDICAL HISTORY

Patient's Name:_____Today's Date:_____

Address***:***_____***(P.O Boxes can NOT be used)***

City:_____State:_____Zip Code _____

Home:_____-_____-_____Work: _____-_____-_____Cell: _____-_____-_____

Email:_____Marital Status:_____

Date of Birth:_____/_____/_____ Gender:_____ Social Security Number:_____-_____-_____

How did you hear about us?_____ Occupation _____

EMERGENCY CONTACT INFORMATION:

Name:_____ Telephone: _____-_____-_____Relationship_____

INSURANCE INFORMATION: ***(ALL INSURANCE PLANS MUST BE PROVIDED TO BILL INSURANCE CARRIERS. ALSO PLEASE READ FINANCIAL POLICY FORM)***

Primary Insurance Name:_____ Ins PH#_____-_____-_____
Policy Holder Name:_____Date of Birth:_____/_____/_____
Policy Owned By: ☐Self OR ☐Other: _____Employer:_____
Policy Holder Name:_____Date of Birth:_____/_____/_____
Social Security Number: _____-_____-_____Policy ID#:_____Group#_____

Secondary Insurance Name: _____ Ins Ph#_____-_____-_____
Policy Holder Name:_____Date of Birth:_____/_____/_____
Policy Owned By: ☐Self OR ☐Other: _____Employer:_____
Policy Owner Address:_____
Social Security Number: _____-_____-_____Policy ID#:_____Group#_____

(*Account Holder's SSN is required to become/stay at patient at Fairfax Dental Center)

MEDICAL HISTORY:

	YES	NO	
Are you taking Birth Control Pills?	☐	☐	
Are you pregnant?	☐	☐	*If Yes, # of weeks:*_____
Are you nursing?	☐	☐	

*****ALL PATIENTS MUST ANSWER ALL QUESTIONS LISTED BELOW*****

Allergies:	YES	NO
Aspirin	☐	☐
Codeine	☐	☐
Dental Anesthetics	☐	☐
Erythromycin	☐	☐
Jewelry	☐	☐
Latex	☐	☐
Metals	☐	☐
Penicillin	☐	☐
Tetracycline	☐	☐

Other Allergies:
_____

Conditions:

	YES	NO		YES	NO
Abnormal Bleeding	☐	☐	Hepatitis A	☐	☐
Alcohol Abuse	☐	☐	Hepatitis B	☐	☐
Anemia	☐	☐	Hepatitis C	☐	☐
Angina Pectoris	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	Hip Replacement Surgery	☐	☐
Artificial Bones	☐	☐	HIV+ Aids	☐	☐
Artificial Heart Valve	☐	☐	Kidney Problems	☐	☐
Asthma	☐	☐	Knee Replacement Surgery	☐	☐
Blood Transfusion	☐	☐	Liver Disease	☐	☐
Cancer-Chemotherapy	☐	☐	Low Blood Pressure	☐	☐
Colitis	☐	☐	Mitral Valve Prolapse	☐	☐
Congenital Heart Defect	☐	☐	Pace Maker	☐	☐
Cosmetic Surgery	☐	☐	Pneumocystis	☐	☐
Diabetes	☐	☐	Psychiatric Problems	☐	☐
Difficulty Breathing	☐	☐	Radiation Therapy	☐	☐
Drug Abuse	☐	☐	Rheumatic Fever	☐	☐
Emphysema	☐	☐	Seizures	☐	☐
Epilepsy	☐	☐	Shingles	☐	☐
Fainting Spells	☐	☐	Sickle Cell Disease	☐	☐
Fever Blisters	☐	☐	Sinus Problems	☐	☐
Frequent Headaches	☐	☐	Smoking/Tobacco Use	☐	☐
Glaucoma	☐	☐	Stroke	☐	☐
Hay Fever	☐	☐	Thyroid Problems	☐	☐
Heart Attack	☐	☐	Tuberculosis	☐	☐
Heart Surgery	☐	☐	Ulcers	☐	☐
Hemophilia	☐	☐	Venereal Disease	☐	☐
			Yellow Jaundice	☐	☐

Please list any medications you may be taking:

_____

_____

_____

_____

Are there any surgeries, condition or problem not listed above which we need to be aware of?

_____

_____

_____

_____

Any dental concerns and/or questions regarding your visit with us today?

_____

_____

Patient Signature:_____**Date:**_____

Print Name:_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Fairfax Dental Center
4000 Virginia Street
Fairfax, VA 22032
(703) 273-1443

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:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- 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 or 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.

Patient Name: _____

Signature: _____ Date: _____

Relationship to Patient: _____

The following 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 Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation

FAIRFAX DENTAL
CENTER

Family and Cosmetic Dentistry

Yolonda L. Weaver, DDS
Nora AlFaysale, DDS

FINANCIAL POLICY

Thank you for choosing Fairfax Dental Center as your dental provider. We are committed to a successful treatment plan and your continued satisfaction. As a courtesy to our patients, we will be happy to complete and forward all insurance claims relative to your dental treatment at no charge.

Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. Insurance balances are ultimately the patient's responsibility. After 60 days, you are responsible to pay the balance in full.

Co-Payments (Estimated Portions) are expected on the day services are rendered. Insurance benefits can not be determined before your appointment; our office may ask you to pay in full for services. It is the patient's responsibility to pay in full for services rendered.

Your scheduled appointment time has been reserved specifically for you. We request 48 hours notice if you need to make any changes to your appointment(s). Any missed/changed appointment without 48 hours notice will have a charge of $65 minimum to your account. It is up to the treating doctor's discretion if the charge is more then the minimum due to the amount of time lost from their schedule. Any accumulation of no shows and/or cancellations without 48 hours notice to any appointments will be grounds for dismissal from the practice. You records will be emailed to you at no additional charge. We ask you kindly to call our 24/7 answering service for any cancellation or change(s) to your appointments at 703-273-1443.

I, the undersigned hereby agree to pay the above practice all fees due for services rendered and/or expenses incurred by me, spouse, or any dependents on my account. Payment is to be made at the time of visit unless otherwise noted. If my account is placed under collections, I agree to pay all charges that incur. I understand that the terms herein are reaffirmed each time services are rendered.

Patient Name: _____

Patient's Signature: _____ Date: _____

Fairfax Dental Center
4000 Virginia Street, Fairfax, VA 22032 Tel: 703-.273-.1443 Fax: 703-273-9186
www.FairfaxDentalCenter.com