Fairfax Periodontal Group

Patient Registration Form

PATIENT INFORMATION:

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Other Social Security #: - -

Last Name:_____ First Name: _____ Middle Initial:_____

Is there a name you prefer to go by? _____

Date of Birth: / / Sex: ☐ Male ☐ Female ☐ Other Single / Married / Div / Sep / Wid

Street Address:_____ Apt:_____ City:_____ State:____Zip:_____

Occupation:_____ Employer: _____

Home #: ( ) - Cell #:( ) - Work #:( ) -

E-mail:_____

Preferred communication: ☐ Call ☐ Text ☐ E-mail

Emergency Contact: _____ Relation:_____ Phone #:( ) -

General Dentist: _____ Phone #:( ) -

Preferred Pharmacy: _____ Phone #:( ) -

How did you hear about our practice?:_____

INSURANCE INFORMATION:

Primary:
Plan Name: _____ Subscriber's Name: _____

Subscriber's Social Security #: - - Subscriber's Date of Birth: / /

Member ID#: _____Group #:_____

Secondary:
Plan Name: _____ Subscriber's Name: _____

Subscriber's Social Security #: - - Subscriber's Date of Birth: / /

Member ID#: _____Group #:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize North Bethesda Periodontal Group and/or my insurance company to release information required to process my claims.

Patient/Guardian Signature: ***Date:***

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Office Policy & Patient Consent/Releases

Please carefully review, *initial*, and sign below:

_____I authorize Dr. Choudhary, Dr. Howantiz and their staff to provide any and all forms of treatment, medication and therapy that may be necessary or advisable in connection with my dental care, or for my dependent. I further consent to Dr. Choudhary, Dr. Howantiz and their and staff choosing and employing such methods and means as is deemed fit. I understand that prior to treatment, a full explanation of the procedure(s) involved will be given by Dr. Choudhary, Dr. Howantiz or their staff, and I agree to ask any questions that I may have, or raise any issues, prior to the start of the treatment. Also, I understand that there are rare but real risks associated with **local anesthesia** such as permanent or temporary paresthesia. I understand those risks and have asked any questions that I may have about them, and consent to local anesthesia being administered to me as part of my dental treatment.

_____I authorize Dr. Choudhary, Dr. Howantiz and their staff to take photographs, study models, and/or radiographs of my face, jaws, and teeth. I understand that these photographs, study models, and/or radiographs will be used as a record of my care and treatment, and further authorize their use for educational or teaching purposes.

_____In consideration of services rendered, I hereby transfer and assign to Dr. Choudhary and Dr. Howantiz, right, title and interest in any payment due for services as provided in the policy or policies of dental insurance(s) held by me. I understand that I am legally responsible for all cost of treatment, regardless of any estimated insurance balance, and that my portion for covered procedures may differ from estimates provided by Dr. Choudhary, Dr. Howantiz and their staff. I further agree and authorize Drs. Choudhary and Howanitz to release any information requested by my insurance company(s) or its representatives. If Drs. Choudhary and Howanitz are not a direct provider for my dental insurance provider, I understand that filing a claim with my dental insurance may be done strictly as a courtesy to me, and that I still remain liable for the full amount of fees for services rendered.

_____I understand and agree that any and all past due balances over thirty (30) days will be subject to a finance charge of 1.5% per month (18% annually). I further agree that where collection activities are employed, whether via collection agencies or legal proceedings, in order to collect any delinquent amounts owed by me, I shall be responsible for all costs of collection, including but not limited to, court costs, interest, and attorney fees in the amount of 33 and 1/3% of the total principal and interest owing on my account, whether or not formal litigation is instituted.

_____In the event that my check or credit card payment is declined or returned, I agree to pay a non-refundable fee of $50.

_____If necessary, I agree to cancel or reschedule any appointment at least 24-hours prior to my appointment time in order to avoid a **$50 non-refundable cancellation fee**. I also agree that being substantially late for an appointment, or missing the appointment altogether, shall be deemed a cancellation, and subject me to the cancellation fee.

"I have read and understood this entire agreement before signing here below, and I have endorsed this agreement voluntarily, without duress, and of my own free will and choice."

Name of Patient or Representative (please PRINT)_____

Signature of Patient or Representative:_____ **Date:** _____

Insurance Benefits and Claims Policy

GENERALLY: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, or if your insurance company has not paid your account in full within 60 days from the date the services were rendered, the balance will become ***payable immediately, regardless of any pending claims***. We require that your complete insurance information 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.

MAINTAINING HIGH STANDARDS FOR CARE: Please be aware that some, and perhaps all, of the services provided may be non-covered services, or may have a charged fee not considered "reasonable and customary", or may be deemed an unnecessary service according to administrators of your insurance policy. The decision(s) of your insurance policy's administrators, particularly regarding the necessity of treatment, are outside of our control. Our practice is committed to providing the best dental care for you, determined by professional and skilled dentists examining you, rather than administrators examining charts and figures about your or the service rendered. Also, we strive to maintain the highest standards in terms of sterilization, materials and laboratory services for our patients. As such, ***we choose not to allow administrators of insurance policies to compromise our level of care or standards***, and trust that our patients appreciate our efforts in this regard. Therefore, each patient joining our practice agrees to be responsible for paying their full balance, less insurance payments received, despite any insurance company's determination regarding the necessity or usual and customary fees charged for services rendered at our office.

FILING CLAIMS: As a courtesy to our patients, we will do our best to verify your dental insurance benefits and also answer any questions you may have about insurance claims. However, ***each patient is responsible for knowing their insurance plan's coverage, exclusions, limitations and usage history***. Furthermore, each patient should be aware of non-covered benefits, including missing tooth clauses, scaling and root planning time and frequency limits, no coverage for implant placement, or soft tissue grafting and other frequency limits (e.g. exams, prophylaxis, fluoride, x-rays). Any estimated amount not expected to be covered by your insurance is due at the time of treatment. Please note that all insurance estimates are subject to final approval by your dental insurance plan, and therefore the amount due is subject to change after final review by your insurance company.

ADDITIONAL LAB FEES: In certain situations, additional lab fees may be necessary and are an additional cost for such procedures (e.g. surgical guides, temporary prosthesis or bridges). You will be advised of any additional lab costs prior to the start of treatment.

"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."

Name of Patient or Representative (please PRINT): _____

Signature of Patient or Representative: _____ **Date**: _____

Fairfax Periodontal Group
Dr. Khalid Choudhary, D.D.S., M.S. & Dr. Joan Howanitz, D.D.S., M.S.

Fairfax Periodontal Group

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

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

Patient's Name (Please Print)

Signature

Name of person(s)/ or entities who are allowed to inquire about patient's treatment

Date

For Office Use Only

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

- ☐ **Individual refused to sign**
- ☐ **Communication barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)**

Fairfax Periodontal Group

NOTICE OF PRIVACY PRACTICES

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 LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect (05/01/2006) and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose heath information about you for treatment, payment and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you. This includes the utilization and submission of claims via electronic means.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement with your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters or e-mails.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstance.
Photographs or Video: Doctors' Choudhary and Howanitz may take photographs or videos of dental procedures for teaching or educational purposes for dental students, health care providers or other oral health care related activities. No personal information except for identifying the treatment will be disclosed.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $20.00 per prorated hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before August 15th, 2006. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact the Office Manager at Fairfax Periodontal Group
Telephone: (703)-639-0245 Fax: (703)-890-3007
Address: 8260 Willow Oaks Corp Drive, Suite #525 Fairfax, VA 22031