Raj Patel, DDS
2757 Jefferson Davis Hwy., Suite 119
Stafford, VA 22554
540-659-2000

Patient Information (Kindly Print Legibly)

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

E-mail Address:_____

Phone (Home): _____ (Work): _____ Ext: _____ Cell:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for Today's Visit: _____

Do you have a history of, or do you currently have, any of the following conditions? Please check those that apply:

- ☐ AIDS
- ☐ Allergy Codeine
- ☐ Allergy Penicillin
- ☐ Allergy Latex
- ☐ Allergy Metals
- ☐ Allergy Rubber
- ☐ Allergy Other

_____
_____
_____

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Transfusions
- ☐ Breathing Difficulties
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic Cough
- ☐ Chemotherapy
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Coronary artery disease
- ☐ Diabetes
- ☐ Dizziness
- ☐ Earaches/ringing in ears
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fever Blister/Cold Sores
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Ache
- ☐ Head Injuries
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart & Valve defects
- ☐ Hepatitis
  - ☐ A
  - ☐ B
  - ☐ C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Care
- ☐ Nervous Disorders
- ☐ Oral Cancer/Tumor
- ☐ Pacemaker
- ☐ Prosthetic Heart
- ☐ Prosthetic Joint(s)
- ☐ **Currently Pregnant** Due date:_____
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Severe Headaches
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Urinate frequently
- ☐ Venereal Disease

OTHER:
- ☐ _____
- ☐ _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No Date of last complete exam?_____
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any medications at this time? ☐ Yes ☐ No Taking Birth Control Pills? _____ Yes _____No

Medication	**Dosage**	**How Often**	**How Long**

Patient Name: _____ **Date:** _____

Do you use tobacco in any form? ☐ Yes ☐ No
If yes, how much? _____ How Long? _____

Have you ever had an allergic reaction to medication/anesthetic? ☐ Yes ☐ No
If yes, what medication(s) _____
What kind of reaction did you have? _____

• Have you ever had any serious trouble associated with dental treatment/surgery/extraction? ☐ Yes ☐ No
If yes please explain? _____

• Have you ever had any complications following dental treatment? _____ Yes _____ No
If yes, please explain: _____

•Have you ever had an unusual reaction to dental anesthetic? ☐ Yes ☐ No
If yes please explain _____

Nearest relative to contact in case of emergency: _____ Phone _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform this office at the next appointment without fail.

X _____ **Date:** _____
Signature of Patient, Parent or Guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Patient Name: _____ **Date:** _____

Consent for Dental Services/ Examination

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. $60 charge for all broken appointments, unless 24 notice is given.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I understand that under Virginia Law, if while examining or treating me, any person employed by or under the direction and control of Raj Patel DDS, Inc. is directly exposed to my body fluids in a manner which may transmit HIV, Hepatitis B & C, I will be deemed to have consented to testing for HIV, Hepatitis B & C infection and to the release of the test results to the exposed person.

I have read the above conditions of treatment and payment and agree to their content.

X_____ **Date:** _____ **Relationship to Patient:** ____
Signature of Patient, Parent or Guardian

X_____ **Date:** _____ **Relationship to Patient:** ____
Signature of Guarantor of Payment/Responsible Party

Insurance Consent

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims. I hearby authorize and direct payment of the dental benefits otherwise payable to me, directly to Raj Patel DDS, Inc.

X_____
Signature of Responsible Party/Parent or Guardian

Raj Patel, DDS
Aesthetic & General
DENTISTRY
2757 Jefferson Davis
Hwy, Suite 119
Stafford, VA 22554
540-659-2000

ALL INSURANCE COPAYMENTS, DEDUCTIBLES, AND ESTIMATED PATIENT PORTIONS ARE DUE ON THE DATE TREATMENT IS PERFORMED.

We accept cash, check, or Visa/MasterCard/Discover.

We offer an extended payment plan with credit approval.

REGARDING INSURANCE

We are happy to accept assignment of insurance benefits from your insurance carrier. As a courtesy to you, we will file your insurance, help you maximize your benefits, and estimate both your insurance coverage and your portion due. Your estimated portion is due by the date of service. Should your insurance company refuse to comply with assignment of benefits, you may be asked to pay your bill in full and be reimbursed by your insurance company. The balance is the patient's responsibility whether the insurance company pays or not. If the insurance company has not paid the account in full within 45 days, the balance becomes the patient's responsibility. Should Raj Patel D.D.S.,Inc. have to expend any fees (collection, court cost, etc.) to collect any payment portion, insurance or other, these fees will automatically become the patient's responsibility. Please be aware that some and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under some dental insurance policies.

Return Check Fee

Any returned check will incur a $ 50.00 NSF fee.

MINOR PATIENTS

The adult accompanying a minor is responsible for seeing that payment is made in full. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements have been made for payment by cash, check, credit card or pre-approved credit plan.

MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. If an appointment must be rescheduled, please give us at least 24 hours notice. For Monday appointments, we need to know of changes by noon on Friday at the latest. It is our policy to charge $60.00 for each missed appointment. Should the problem continue, you may be asked to prepay appointments to reserve the appointment time.

AGREEMENT TO PAY COLLECTION FEES ADDED TO ACCOUNT BALANCES

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Virginia and any other State.

CONSENT TO CONTACT PATIENT BY CELL PHONE OR E-MAIL

You agree, in order for us to service your account or to collect monies you may owe, Raj Patel D.D.S. Inc. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which can result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Please let us know if you have any questions or concerns regarding our Financial Policy. We look forward to serving your dental needs.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party _____ Date _____

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STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your heath information is never comprised is a principal concept of our practice. We may from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTH INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accounting Act and the state of Virginia. This includes issues relating to your treatment, payment and out dental care operations. Your health information will never be otherwise given to anyone even family members-without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future employees, so you can be confident that your protected heath information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION

We only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history records, ect. While most information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use information for marketing purposes without your written consent.
We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, postcards, email, & cell phone.

PATIENT RIGHTS

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information fro uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient in our practice. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Raj Patel D.D.S. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and responsibilities and the duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Raj Patel, D.D.S. reserved the right to change the privacy practice that is described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practice by requesting that one be mailed to me.

_____

Name of Patient or Personal Representative

_____ _____

Signature of Patient of Personal Representative **Date**