2 Cardinal Park Drive, Suite 204A Leesburg, VA 20175
ashton@leesburgfamilydental.com
(703) 779-2296

Date:_____

PATIENT INFORMATION: Please enter information for the PATIENT ONLY in this section.

Name:_____ Birth Date:_____ Cell Phone:_____

Sex: ☐ M ☐ F Status: ☐ Married ☐ Single ☐ Minor

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone: (___)_____ Work Phone(___)_____ Email:_____

Whom may we thank for referring you?_____

Emergency Contact:_____ Emergency Contact Phone: (___)_____

RESPONSIBLE PARTY: Please enter info for the PERSON RESPONSIBLE FOR PAYMENT OF SERVICES OR IS THE SUBSCRIBER OF THE INSURANCE. Please Note: If the patient is a minor (under age 18), the adult and/or guardian accompanying the patient to any treatment visit is responsible for payment of services.

Relationship to Patient: Self / Spouse / Parent / Other_____ Cell Phone:(___)_____

Name:_____ Gender: ☐M ☐ F Social Security #___-___-___ DOB:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Drivers License #:_____ Employer:_____ Work Phone:(___)_____

DENTAL HISTORY:

Reason for today's visit/any concerns:_____

Former Dentist:_____ Former Dentist Phone:_____

Date of last dental visit :_____ Date of last dental xrays:_____

How often do you floss?_____ How often do you brush?_____

Check if you have had any problems with the following:

☐ Bad breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food collection between teeth
☐ Grinding teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in your mouth

MEDICAL HISTORY:

Physician's Name:_____ Physician's Phone:(_____)_____Date of last Visit:_____

Have you ever used a bisphosphonate medication? Common Brand Name: Fosamax, Actonel, Atelvia, Didronel, Boniva.
☐ Yes ☐ No
Have you ever needed to pre-medicate with antibiotics before a dental visit/treatment? ☐ Yes ☐ No

Are you taking any blood thinners? ☐ Yes ☐ No

Allergies or reactions to: Antibiotics / Pain Medicines / Local Anesthetics / Latex / Other:_____

_____

Please list any prescriptions or over the counter medications you are currently taking:_____

_____

Have you ever been hospitalized for any surgery or serious
illness?_____

If Female: Are you taking hormones or birth control? ☐ Yes ☐ No
Are you pregnant or nursing ☐ Yes ☐ No Is there a possibility that you may be pregnant? ☐ Yes ☐ No

Please mark on "Yes" or "No" to indicate if you have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Congenital Heart Lesions	☐	☐	Hepatitis	☐	☐	Scarlet Fever
☐	☐	Arthritis, Rheumatism	☐	☐	Cortisone Treatments	☐	☐	Hernia Repair	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valve	☐	☐	Cough Persistent	☐	☐	High Blood Pressure	☐	☐	Skin Rash
☐	☐	Artificial Joints, Pins	☐	☐	Cough up Blood	☐	☐	HIV/AIDS	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Swelling of Feet/Ankle
☐	☐	Back Problem	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Thyroid Problems
☐	☐	Bleeding abnormally	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Tobacco Habit
☐	☐	Blood Disease	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Cancer	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐	Ulcer
☐	☐	Chemotherapy	☐	☐	Heart Problems	☐	☐	Respiratory Disease	☐	☐	Venereal Disease
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Rheumatic Fever	☐	☐	Osteoporosis treatment

AUTHORIZATION AND RELEASE:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a health change.

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Cardinal Park Family Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Cardinal Park Family Dental Care may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or in one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are happy to have you as our patient and look forward to offering you and your family the highest quality lifetime dental care.

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please Note: Any deductible or estimated co-payment will be due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and Care Credit.

Please Note: Appointments are reserved exclusively for you. If an appointment is not canceled at least 48 hours in advance, or if you fail to keep your appointment, you will be charged a thirty-five dollar ($35) fee. Any missed appointment 2 hours or more in length will incur a one hundred dollar ($100) fee. This fee will not be covered by your insurance company.

Insurance benefits are determined by your employer. Please contact your insurance company for a detail of your benefits. We will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums. We will be happy to file your claim for you if you present your dental insurance card and all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.

ASSIGNMENT OF BENEFITS

I authorize my insurance company to pay the office of **Dr Gary Ashton** all benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance claim submissions.

I authorize the office of **Dr. Gary Ashton** to release all information necessary to secure payment of insurance benefits.

I understand that I am financially responsible for all fees regardless of whether or not they are covered by insurance.

I have read, understand and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at **Cardinal Park Family Dental.**

Patient/Guardian
Signature_____Date_____

CARDINAL PARK FAMILY DENTAL CARE
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name:_____ Date of Birth:_____

TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Office Manager. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURES

I, _____, have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____
Relationship to Patient:_____

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____
Relationship to Patient:_____