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

<u>Patient Treatment and Financial Policy</u>

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:_________________________

<u>**COVID-19 Pandemic Dental Consent Form**</u>

I, _________________________________ **(PRINT NAME),** knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period. Carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has the virus and who does not have the virus given the current limits in virus testing.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. __________ **(initial)**

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat

_________ **(initial)**

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has traveled. ________ (initial)

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. ________ **(initial)**
- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. ________ **(initial)**

Have you tested positive for COVID-19 or have you been in contact with anyone who has been infected with COVID-19? ________________ If YES, How long ago?
____

Signature ____ **Date** ____________________