Arlington Advanced Dental Care
Hossein Ahmadian D.D.S
1010 N Glebe Rd Suite 120
Arlington, VA 22201
703-974-7501

PATIENT INFORMATION

Date: _____ **SS#:** _____ **Email address:** _____

Patient's Last Name: _____ **First Name:** _____**M. Initial:** ____

Date of Birth: _____/____/_____ **Age:** ____ **Sex:** ○ Male ○ Female **Marital Status:** _____

Address: _____**City:** _____ **State:** ____ **Zip:** _____

Home Phone: _____**Cell Phone:** _____ **Work Phone:** _____

Patient Employed by: _____ **Occupation:** _____

Whom may we thank for referring you? _____

In case of an emergency who should be notified? _____ **Phone #:** _____

PRIMARY INSURANCE INFORMATION

Patient Is: □ Policy Holder □ Responsible Party □ Dependent of Policy Holder

Person Responsible for Account:

Last Name: _____ **First Name:** _____ **SS#:** _____

Date of Birth: ____/____/_____ **Relationship to Insured:** ○ Self ○ Spouse ○ Child

Address (if different from patient): _____

Person Responsible Employed by: _____ **Work Phone:** _____

Insurance Company:_____ **Subscriber #:** _____

Group #: _____ **Phone#:** _____

Is the patient covered by additional insurance? □Yes □ No

Subscriber Name: _____**Birth Date:** _____/___/_____ **SS#:** _____

Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other **Subscribe ID#:** _____

Insurance Company: _____ **Group#:** _____ **Phone:** _____

Health History Form

Patient Name: _____Birth Date: _____

Physician's Name: _____**Date of Last Visit: _____**

**Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

Have you had any serious illnesses or operations?: □ Yes □ No **If yes, describe:**_____

Have you ever had a blood transfusion?: □ Yes □ No **If yes, give approximate dates:**_____

(WOMEN) Are you pregnant? □ Yes □ No **If yes, how many wks/months? _____**

NURSING? □ Yes □ No **Taking birth control pills?** □ Yes □ No

Medication List

Name of Medication	How Often Taken	Dosage

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING, WRITE "N/A" IF NONE APPLY:

___Anemia	___Cortisone Treatments	___Hepatitis	___Scarlet Fever
___Arthritis, Rheumatism	___Cough, Persistent	___High Blood Pressure	___Shortness of Breath
___Artificial Heart Valves	___Cough up Blood	___HIV/AIDS	___Skin Rash
___Artificial Joints	___Diabetes	___Jaw Pain	___Stroke
___Asthma	___Epilepsy	___Kidney Disease	___Swelling of Feet/Ankle
___Back Problems	___Fainting	___Liver Disease	___Thyroid Problems
___Blood Disease	___Glaucoma	___Mitral Valve Prolapse	___Tobacco Habit
___Cancer	___Headaches	___Pacemaker	___Tonsillitis
___Chemical Dependency	___Heart Murmur	___Radiation Treatment	___Tuberculosis
___Chemotherapy	___Heart Problems	___Respiratory Disease	___Ulcer/Stomach Ulcer
___Circulatory Problems	___Hemophilia	___Rheumatic Fever	___Venereal Disease

Are you allergic to any of the following?

• Aspirin •Penicillin •Codeine •Acrylic •Metal •Local Anesthetics •Other •None

Do you have to PRE-MEDICATION (antibiotics) before any dental treatment? □ Yes □ No
If yes, please explain: _____

Dental History

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

Do you smoke cigarettes? □Yes □ No **If yes, how many cigarettes per day**?

_____

Reason for today's visit: _____

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

Chief Complaints	**Previous Dental Treatment**
Do you have any tooth/jaw pain? □Yes □ No Sensitivity to □ cold □ hot □sweets □ biting Loose teeth? □Yes □ No Swelling or bleeding gums □Yes □ No Bad breath □Yes □ No Sores or growths in your mouth □Yes □ No Missing teeth? □Yes □ No Appearance of your teeth □Yes □ No Are you happy with your smile □Yes □ No Other _____	Orthodontic braces □Yes □ No Crowns or bridges □Yes □ No Dental or jaw surgery □Yes □ No Extractions □Yes □ No Dental implants □Yes □ No Periodontal treatment □Yes □ No If yes, how long ago_____

Dental Appliance

Do you wear any removable partial or full denture? □Yes □ No

If yes, are you pleased with the appearance? □Yes □ No Do you wear it daily? □Yes □ No

Are you able to chew any food? □Yes □ No **Do you wear night guard?** □Yes □ No

Are you interested in permanent placement/Implants? □Yes □ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing the 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 /Legal Guardian: _____ Date: _____

Assignment of Insurance Benefit

I authorize the use of this signature on all insurance submissions. The patient/undersigned understands that insurance is a contract between the patient and the insurance company not this office, and agrees that the dental office is not liable for any errors or omissions related to insurance claims filings. I authorize the dentist to release all information necessary to secure the payment of benefits. *I understand that filing of my dental insurance is done as a courtesy to me.*

Agreement to Pay For Services Rendered

I agree to pay for all services rendered by Arlington Advanced Dental Care. I further understand that I am legally responsible for all charges whether or not paid by insurance. If the patient is a minor, the undersigned agrees to these terms of financial responsibility. I also understand if my account balance becomes delinquent (over 30 days); I agree to pay a $45 collection fee and a finance charge of 1.5 % (18 % annually) per month, as allowed by the laws of the state of Virginia.

Cancellation Policy and Missed Appointments

Broken appointments are not fair to any of the parties involved. In order to recoup and recover expenses incurred by broken appointments the broken appointment fee is $60 per hour. These charges are assessed to patients that have not given our office **48 hours** "2 **business days**" notice, especially if charges have been waived previously.

Print Name of Patient: _____

Authorized Signature:_____ **Date**:_____

NOTICE OF PRIVACY PRACTICES AND HEALTH INFORMATION

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. A full copy of the privacy practice notice and health information is available for your review per request.

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 June 1st of 2012, 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 health 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.

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/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.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

QUESTIONS AND COMPLAINTS

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.

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Signature of Patient /Legal Guardian: _____ Date: _____