Dream Smile Family Dentistry
24805 Pinebrook Rd, Suite 212, Chantilly VA 20152
703-327-9908

PATIENT INTRODUCTION AND HISTORY

Patient History
Patient Name_____ Today's date _____

Date of Birth _____ Sex ☐ Male ☐ Female

Reason for this visit_____

Referred or recommended to us by _____

Allergies to:
Latex: Yes ☐ No ☐ **Blood pressure:**

Allergies to medications: _____

Allergies to other: _____

DENTAL HISTORY		PAST DENTAL HISTORY	Y	N
Previous Dentist:		One or more fillings in the last 3 years?	☐	☐
Last Dental Visit:		Family history of extensive decay?	☐	☐
Last Dental Cleaning:		Treatment for gum (periodontal) disease?	☐	☐
Frequency of Dental Exam:		Family history of gum (periodontal) disease?	☐	☐
Frequency of Brushing:		Have you had (orthodontics) braces?	☐	☐
Frequency of Flossing:		Have you had any dental implants?	☐	☐
What are some typical foods eaten between meals:		Treatment for tempormandibular disorders?	☐	☐
What types of beverages do you typically drink:		Do you wear denture(s) or partial denture(s)?	☐	☐

DO YOU HAVE CONSISTENT PROBLEMS WITH:	Y	N		Y	N
Dry mouth/excessive thirst?	☐	☐	Difficulty chewing?	☐	☐
Sensitive teeth? Hot Cold Sweets Pressure	☐	☐	Food catches between teeth?	☐	☐
Mouth odors/ bad taste?	☐	☐	Teeth/filling break frequently?	☐	☐
Cold sores/blisters/oral lesions?	☐	☐	Clenching/grinding habits?	☐	☐
Are you aware of any swelling or lumps?	☐	☐	Do you hear popping, clicking, or snapping?	☐	☐
Sore, bleeding gums?	☐	☐	Do you have jaw pain?	☐	☐
Loose teeth?	☐	☐	Are you nervous about dental work?	☐	☐

MEDICAL HISTORY

Medication	DOSAGE	FREQUENCY

PAST AND CURRENT MEDICAL CONDITIONS (MARK ALL THAT APPLY)

	Y	N		Y	N
Under physician's care Details:	☐	☐	Tuberculosis	☐	☐
Hospitalization/operation(s) in last 5 years Details:	☐	☐	Sinus trouble	☐	☐
Head/neck/mouth injuries	☐	☐	Cancer	☐	☐
Women: pregnant	☐	☐	Radiation Treatment to Head/Neck	☐	☐
Nursing	☐	☐	Chemotherapy	☐	☐
oral contraceptives	☐	☐	Kidney disease	☐	☐
Heart trouble/disease	☐	☐	Dialysis	☐	☐
Rheumatic fever	☐	☐	Eating disorder	☐	☐
Past use of Fenphen	☐	☐	Stomach: Reflux/ulcer	☐	☐
Heart murmur	☐	☐	Immunological disease	☐	☐
Mitral valve proplapse	☐	☐	Sjogrens disease	☐	☐
Heart surgery	☐	☐	Fibromyalgia	☐	☐
Artificial heart valves	☐	☐	Other autoimmune disease (lupus, pemphilus)	☐	☐
Pacemaker	☐	☐	Arthritis or other joint disorders	☐	☐
Indwelling defibrillator	☐	☐	Diabetes: Type Controlled ☐ Yes ☐ No	☐	☐
Artificial joints	☐	☐	Headaches	☐	☐
History of organ transplant	☐	☐	Depression	☐	☐
High blood pressure	☐	☐	Other psychiatric disorders	☐	☐
Stroke	☐	☐	Neurologic disease	☐	☐
Bleeding problem	☐	☐	Convulsions	☐	☐
Hemophilia	☐	☐	Epilepsy/seizures	☐	☐
Anemia	☐	☐	Cerebral palsy	☐	☐
Leukemia	☐	☐	Fainting/dizziness	☐	☐
Lung disease	☐	☐	Venereal disease	☐	☐
Emphysema	☐	☐	AIDS/HIV positive	☐	☐
Shortness of breath	☐	☐	Alcohol or chemical dependency	☐	☐
Asthma	☐	☐	Hepatits	☐	☐
Sleep apnea	☐	☐	Thyroid disease	☐	☐
Glaucoma	☐	☐			

THIS IS MY AUTHORIZATION TO DR. ARCHANA REJINTALA, FOLLOWING EXPLANATION OF THE PROCEDURES, METHODS AND MEDICATIONS INVOLVED, TO PERFORM ALL NECESSARY DIAGNOSTIC, PREVENTIVE, RESTORATIVE, SURGICAL, ORTHODONTIC AN ASSOCIATED DENTAL TREATMENT. THE INFORMATION I HAVE PROVIDED IS, TO THE BEST OF MY KNOWLEDGE, ACCURATE AND COMPLETE. I AUTHORIZE AND CONSENT TO THE RELEASE OF ALL INFORMATION CONCERNING MY DENTAL HEALTH AND TREATMENT HISTORY TO 3RD PARTY PAYERS AND TWO OTHER HEALTH PROFESSIONALS. THIS CONSENT IS TO REMAIN IN EFFECT UNTIL CANCELLED IN WRITING.

Signature_____ Date_____

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FINANCIAL RECORD

Residence address _____ City _____ Zip _____

Residence phone _____ Cell Phone _____

**Email: _____

☐ Please check here if you do not wish to receive email correspondence.

Full name _____ Marital Status _____

Social Security number _____

Occupation _____ Employed by _____

Spouse's full name _____

Social Security number _____

Address if different _____

Occupation _____ Employed by _____

Have any family members been patients in our office in the past? If so, please list:

_____

If family is not living together, person financially responsible for account _____

DENTAL INSURANCE INFORMATION

First Policy

Name of policy holder _____

Social Security # _____ ID # _____ Birthdate _____

Insurance name _____ Employer _____ Group/policy # _____

Second Policy

Name of policy holder _____

Social Security # _____ ID # _____ Birthdate _____

Insurance name _____ Employer _____ Group/policy # _____

Assignment of Benefits

I hereby authorize payment of insurance benefits otherwise payable to me directly to Dr. Archana Rejintala. I understand that I am financially responsible for all charges not reimbursed by my insurance carrier(s). I authorize and consent to the release of dental and financial information necessary for the filing of insurance claims

Signature _____ Date _____

THE INFORMATION I HAVE GIVEN IS, TO THE BEST OF MY KNOWLEDGE, ACCURATE AND COMPLETE. I UNDERSTAND THAT I AM RESPONSIBLE FOR, AND AGREE TO THE PAYMENT OF, ALL CHARGES IN CURD IN THE OFFICE IN THE CARE AND TREATMENT OF MY FAMILY MEMBERS. IN THE EVENT THAT FINANCIAL RESPONSIBILITY CHANGES, I UNDERSTAND THAT I AM STILL RESPONSIBLE UNTIL NEW FINANCIAL RESPONSIBILITY IS ESTABLISHED AND ACCEPTED BY DR. ARCHANA REJINTALA. IF PAYMENT OF ANY BALANCE IS NOT RECEIVED WITHIN 90 DAYS OF 1ST STATEMENT DATE, ACCOUNT WILL BE SENT TO COLLECTIONS, AND MY BALANCE WILL BE

INCREASED BY 33.3%. THIS ACCEPTANCE OF FINANCIAL RESPONSIBILITY IS TO REMAIN IN FORCE UNTIL CANCELLED IN WRITING.

Signature _____ Date _____

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Cancellation and Scheduling Policy

We require a **two**-business day advanced notice for any changes or cancellations of your appointment. For appointments over an hour we require a **three**-business day advanced notice. This allows us the time we initially reserved especially for you in our schedule to be filled by another patient who may have been waiting for this appointment time. We do, however, understand that illness and emergencies occur and we do accommodate for those rare instances.

If you arrive more than 15 minutes late for your scheduled appointment and we cannot accommodate you, you will be charged the cancellation fee.

A $75 fee will be charged to your account for not honoring this policy. Please note that this fee will not be billed to your insurance and you will be required to pay this fee before your next appointment.

We reserve time in our schedule for you in advance in order to accommodate your busy schedule. We ask for a deposit to reserve appointments scheduled for over an hour. The deposit is a third of your estimated patient portion for the treatment scheduled.

We ask that you give us the same consideration when needing to change or cancel your appointment.

I UNDERSTAND THAT THERE IS A 48-HOUR CANCELLATION POLICY. I UNDERSTAND THAT A $75 FEE WILL BE CHARGED IF I FAIL TO KEEP MY APPOINTMENT OR DO NOT CANCEL AT LEAST 48 HOURS IN ADVANCE

Signature_____ Date_____

Our Office Policy Regarding Dental Insurance – Dream Smile Family Dentistry

If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. By law your insurance company is required to pay each claim within 30 days of receipt. We file all insurance electronically, so your insurance company will receive each claim within days of the treatment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. If you have not paid your balance within 60 days a re-billing fee of 1.5% will be added to your account each month until paid. We will be glad to send a refund to you if your insurance pays us.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. Please be advised that if you have any treatment at another office, you may not have your full maximum coverage available. We also cannot be responsible for any errors in filing your insurance. Once again, we file claims as a courtesy to you.

Fact 1 - NO INSURANCE PAYS 100% OF ALL PROCEDURES
Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. This is not true! Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage, or the type of contract your employer has set up with the insurance company.

Fact 2 - BENEFITS ARE NOT DETERMINED BY OUR OFFICE
You may have noticed that sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company.
A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable, or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate.

Insurance companies set their own schedules, and each company uses a different set of fees they consider allowable. These allowable fees may vary widely, because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR Fee. Frequently, this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit.

Unfortunately, insurance companies imply that your dentist is "overcharging", rather than say that they are "underpaying", or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

Fact 3 - DEDUCTIBLES & CO-PAYMENTS MUST BE CONSIDERED
When estimating dental benefits, deductibles and percentages must be considered. To illustrate, assume the fee for service is $150.00. Assuming that the insurance company allows $150.00 as its usual and customary (UCR) fee, we can figure out what benefits will be paid. First a deductible (paid by you), on average $50, is subtracted, leaving $100.00. The plan then pays 80% for this particular procedure. The insurance company will then pay 80% of $100.00, or $80.00. Out of a $150.00 fee they will pay an estimated $80.00 leaving a remaining portion of $70.00 (to be paid by the patient). Of course, if the UCR is less than $150.00 or your plan pays only at 50% then the insurance benefits will also be significantly less.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

I, _____ understand the Office Policy regarding Dental Insurance.

_____
Patient Signature

Oral Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient. One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but more than 25% of oral cancer victims have no such lifestyle risk factors. Studies also suggest that human papillomavirus (HPV) plays a role in more than 20% of oral cancer causes.*

Oral cancer risks by patient profile are as follows:

Increased risk: patients ages 18-39; sexually active patients (HPV)

High risk: patients age 40 and older; tobacco users (ages 18-39, any type within 10 years)

Highest risk: patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

We have recently incorporated VELscope (Visually Enhanced Lesion scope) into our oral screening standard of care. We find that using VELscope along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope, along with the doctor's visual exam, is similar to other proven early cancer detection procedures, such as mammogram, Pap smear, and PSA test. VELscope is a simple and painless examination that gives the best chance to find any abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The VELscope exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. **The fee for this enhanced examination is $25 without insurance coverage**.

❒ Yes. I would prefer to have the VELscope exam at this time.

❒ No. I would prefer not to have the VELscope exam at this time.

Print Name _____

Signature _____ Date _____

*U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, NIDCR, NIH, 2000