Candace E. Evans, D.D.S.

Quality Comprehensive Family Dental Care

Patient Registration (Please fill out completely)

Patient Name ____
Address ______________________ City ______________State ______Zip ______
Home Phone ______________ Work Phone ____________ Cell Phone ____________
Patient SS# ______________ Birth date ___/___/___ Marital Status ______ Sex ____
Employer ______________________ Occupation ______________________
Spouses' Name __________________ Spouses' Employer __________________
If minor, Parent's Names 1) __________________ 2) __________________
Parent's Employers 1) __________________ 2) __________________
Your previous Dentist __________________ Your Physician ______________
Referred by ____________________ Your E-mail ______________________

Dental Insurance Coverage

Dental Insurance Company Name __________________ Effective Date __________
Address ______________________ City ____________State ______Zip _______
Phone Number ______________ Group # ____________ I.D. # ______________
Subscriber's Employer ________________ Subscriber is: Self__ Spouse__ Parent__
Subscriber's Name __________________ SS # __________ Birth date ___/___/___
Do you have secondary ins.? Yes __ No __ Carrier Name ______________ID# _______

Medical History

When was your last complete physical exam? ______________________________

Are you being treated by a physician at this time? Yes ____ No ____
For what? ____

Are you taking pills, drugs or medications? Yes ____ No ____
Please list ____

Are you allergic to; aspirin ___, codeine ___, local anesthesia ___, penicillin ___,
latex ___, or any other medications (list) ______________________________

Have you ever had any of the following?

	Yes	No
Heart attack or disease		
High blood pressure		
Heart murmur		
Mitral valve prolapse		
Rheumatic fever		
Problems with fainting		
Excessive bleeding/clotting		
Anemia		
Diabetes		
Hepatitis/other liver disease		
Alcohol or drug dependency		
Arthritis		
Joint replacement		

	Yes	No
Kidney disease		
Epilepsy		
Sinusitis		
Asthma		
Pneumonia		
Tuberculosis/lung disease		
Frequent vomiting		
Ulcers		
HIV (AIDS) positive		
Do you smoke?		
If yes, how much		
Maligancy		
If yes, type & year		

List any other serious illnesses ______________________________________

Women: Are you pregnant? Yes__ No__ If so - how many months? __________
Have you reached menopause? Yes__ No__

Name: ____

DENTAL HISTORY

When did you have your last dental exam: _______________ Dental x-rays: ___________

Was treatment recommended? Yes__ No__

Was treatment completed? Yes__ No__

Have you ever had teeth extracted? Yes__ No__

Have you had a dry socket after extractions? Yes__ No__

Are your teeth sensitive to sweets? Yes__ No__

Are your teeth sensitive to hot? Yes__ No__ / Cold: Yes__ No__

Do your gums ever bleed? Yes__ No__

Have you noticed any loose teeth? Yes__ No__

Have you ever been diagnosed with or treated for periodontal disease? Yes__ No__

Have you had any bad odors in your mouth even after brushing? Yes__ No__

Have you had dental disease control instructions? Yes__ No__

How often do you brush? ____________ Floss? ____________

Have you ever had your teeth straightened? Yes__ No__

Do you grind or clench your teeth ever while awake or asleep? Yes__ No__

Have you ever had an unpleasant dental experience? Yes__ No__

Are you pleased with the appearance of your teeth? Yes__ No__

Do you usually use local anesthesia for dental treatment? Yes__ No__
Nitrous oxide (laughing gas)? Yes__ No__

Do you have any fillings that feel rough or areas where food collects?
Yes__ No__ Where? ____

Do you suffer from cold sores or fever blisters (herpes simplex virus)?
Yes__ No__ How Often? ____

Do you suffer from canker sores? Yes__ No__ How often? __________

What do you feel the condition of your mouth is?
Excellent__ Good__ Fair__ Poor__

Do you require antibiotics before dental work (i.e., due to a heart murmur/mitral valve prolapse/joint replacement)? Yes__ No__

Have you bleached your teeth? Yes__ No__ What product did you use? ____________

Is there any particular treatment you would like to discuss? ___________________

____

PATIENT AUTHORIZATION & ASSIGNMENT

I have answered all questions to the best of my knowledge. I hereby authorize Candace E. Evans, D.D.S. to apply for benefits on my behalf for services rendered and that payment be made directly to her. I understand that insurance is considered a method of reimbursing her for services provided and is not a substitute for payment in full, which is ultimately my responsibility. By signing this form I also acknowledge receipt of the NOTICE OF PRIVACE PRACTICES and authorize Candace E. Evans, D.D.S. to disclose protected health information to carry out treatment, payment activities, healthcare operations, and record transfer requests described therein.

____ ___________________________

Signature (parent if minor) Date

Candace E. Evans, D.D.S.

Quality, Comprehensive Family Dental Care

NOTICE OF PRIVACY PRACTICES

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 the Notice while it is in effect. This Notice takes effect 04/14/03, 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 physicians, other healthcare provider or technicians providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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 and 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. If you are a **dependent** over 18, we may share this information with your parents.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as leaving messages with a family or staff member; voicemail messages at home, your office or cell phone; postcards; or letters. We may also leave messages pertinent to your care, such as a reminder to take pre-medication or to bring new insurance information.

PATIENT RIGHTS

Access: You have the right to review or obtain copies of your health information, with limited exceptions. You may request that we provide a record summary of your health care or simply a photocopy of your record. We will use the format you request unless we cannot practically do so. You may request that we provide copies of your recent radiographs. Record summaries and copies of recent radiographs can be released to YOU UPON YOUR VERBAL REQUEST. Please allow a minimum of two weeks for record transfers. If you wish your records to be transferred to any other medical provider or individual, you must make a request in writing. You may obtain a form from our office administrator to request such access or you may simply send us a letter stating your request. We will charge you a reasonable cost-based fee for expenses such as records search, summarization, compilation, and photocopying as well as a fee for the duplication of radiographs.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means to or alternative locations. [You must make your request in writing.] Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made our 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 an alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Contact Office: Office Administrator

Telephone: 703-569-2137

Address: 6203 Old Keene Mill Ct., Springfield, VA 22051

Candace E. Evans, D.D.S.

Quality, Comprehensive Family Dental Care

AUTHORIZATION FOR CLAIMS, PAYMENT AND REVIEWS

Thank you for selecting us as your dental provider. We are committed to providing you with quality dental care. Please understand that payment of your bill is considered a part of your treatment. We require that you read the following statement of our office policies and sign this form prior to any treatment.

Full payment for professional services is due at the time of service. We accept cash, checks, Visa, MasterCard, Discover or CareCredit. We will work as an advocate on your behalf with your insurance carrier. However, it must be remembered that insurance is not a substitute for payment. <u>You are ultimately responsible for all fees incurred.</u>

1. We **DO NOT** accept any HMO/DMO plans. If you have any of these plans, we require payment in full at time of service and you will be unable to claim any benefits from your insurance carrier.
2. We **DO NOT** accept Medicaid or Medicare.
3. We are a Preferred Provider for DELTA DENTAL PREMIER. You are responsible for all co-payments, deductibles, uncovered services, etc. We will accept insurance reimbursement per your policy for the remaining balance up to 30 days.
4. We **DO NOT** have a relationship with BC/BS FEP or BC/BS NCA. If you subscribe to either of these plans, you must pay us in full at the time of service, and we will file your insurance claim so that they can reimburse you. If you have a secondary insurance, we will assist you in filing that as well. Unfortunately, they will not communicate (or pay) non-providers.
5. We accept many third party (indemnity) insurance policies as a COURTESY to our patients. We will ASSIST YOU in filing claims, sending radiographs, explanations, pretreatment authorizations, etc. We accept no responsibility for your insurance coverage; i.e., exclusions, deductibles, maximums, uncovered services, fee allowances, etc. Your individual plan is determined by the particular policy purchased by you or by your employer on your behalf. We reserve the right to deny acceptance of insurance reimbursement and require direct payment to our office if we are unfamiliar with an insurance plan or if you fail to provide us with all the necessary insurance documentation. If we accept insurance reimbursement, we expect your portion to be paid at the time of service. You as a policy holder are responsible for exclusions, prerequisites, enrollment, waiting periods, student eligibility status, pre-existing conditions, uncovered services, co-payments, deductibles, maximums, differences in fee allowances, and the need for pretreatment authorization. **REMEMBER THAT WE HAVE NO AGREEMENT WITH YOUR INSURANCE COMPANY; THE AGREEMENT EXISTS BETWEEN YOU AND YOUR INSURANCE COMPANY OR BETWEEN YOUR EMPLOYER AND YOUR INSURANCE COMPANY.** If your insurance does not pay on your claim after 30 days we expect payment in full from you.
6. You will be given a statement summarizing the services rendered at your appointment. This statement indicates your portion due which is expected on the day of service. Dental Insurance Estimates ("Dental Ins. Est.") and "Please Pay amounts are based on insurance estimates and are provided as a courtesy. In the event that your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance in full.
7. You agree to pay interest in the amount of 1.25% along with a late fee charge in the amount of $25 per month for any unpaid fees owed by you (15% per annum).
8. You agree to pay a broken appointment for cancellations made with less than 24 hours notice, at the rate of $50 per ½ hour per family member.
9. You agree to pay a returned check fee of $35 for each returned check.
10. Balances referred to collection services are subject to additional fees; i.e., unpaid balance, attorney/collection fees (30% of the claim, court costs, 15% per annum interest from the date of delinquency (>30 days), and all collection costs incurred with pursuing this balance.
11. NOTE: Cell phones are a distraction to the staff and other patients. We require that you turn your phone off upon entering the office. If you have a situation that requires you to be available, you may leave your phone at the front desk to be answered.

By signing below, I certify that I have read and understand the Authorization for Claims, Payment and Reviews. I further certify that I am the patient or guardian, duly authorized representative, parent or other family member of the patient. I agree to pay all charges for which I may be legally responsible including, but not limited to deductibles, co-payment and non-covered services. In the event my account goes to collections, I agree to pay all fees associated in settling the balance. I agree to accept dental treatment in this office for myself and/or my dependents. I understand that on occasion, some teeth that have undergone restorative treatment may eventually need root canal therapy. This is not something caused by the treating dentist, but rather a result of pulpal insult caused by decay or trauma, or by a tooth having undergone repetitive restorations over time.

Patient Name (please print): ______________________________________

Signature of Patient or Responsible Party: _________________________________ Date: ____________________________