HERNDON DENTAL CENTER

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

How did you hear about us? (Friend,Relative,Phone Book) _____

Patient Information:

Patient's Name: _____ Male / Female:
Last First Middle Preference

Address: _____
Street Apt. # City State Zip

Date of Birth: _____ Social Security #: _____

*(Please provide **all** telephone numbers to contact you. There may be times when we need to reach you on short notice.)*

Home: _____ Work: _____ ext Cell: _____

Email: _____

Emergency Contact Information:

Name: _____

_____ Phone: _____

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

Subscriber Responsible Party Information:

Name: _____ Male / Female DOB: _____
Last First Middle

Social Security #: _____ Relation to patient: _____

Mailing Address: _____

_____ City: _____

_____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ ext _____

Employer: _____ Occupation: _____

Address: _____ No. Years Employed: _____

Primary Dental Insurance (Leave blank only if no dental benefits)

Ins. Company Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Group No.: _____ Id Number: _____

Secondary Dental Insurance (Leave blank only if no dental benefits)

Ins. Company Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Group No.: _____ Id Number: _____

Additional Information

Preferred Pharmacy& Phone: _____

School Name: _____

School Location: _____

Student Status: Full-time or Part-time

Broken Appointment Policy:

Reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion. So that the dentist, our staff, and our other patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that failure to give sufficient warning to keep a scheduled appointment, (48 hours advance notification), will result in a $50.00 fee being charged per ½ hour. That charge

which is in accordance with our dental office's broken appointment policy for all of our patients is to be paid prior to the scheduling of any new appointment. The patient is responsible for payment of the charge.
Please feel free to discuss this and other policies with our office staff.

Patient's Signature:_____

Date:_____

Parent/Guardian signature if patient is a minor:_____

Dental History:

1. Reason for this visit _____
2. Name of previous dentist _____
3. Date of last complete series of dental x-rays_____ Date last treated _____
4. Are you having pain at this time? _____ YES **NO** If yes, where, and for how long?: _____
5. Do you require antibiotics prior to dental treatment? _____ **YES NO**
6. Have you ever had any of the following?
   a. Orthodontic treatment? Braces - Year _____ **YES NO**
   b. Oral surgery? Extractions - Year _____ **YES NO**
   c. Periodontal treatment? Gum Treatment - Year _____ **YES NO**
6. Do you feel very nervous about having dental treatment? _____ YES **NO**

Medical History:

1. Are you in good health? _____ YES **NO**
2. Has there been a change in your general health within the past year?. _____ YES **NO**
3. Are you under the care of a physician during the past two years? _____ YES **NO**
   a. Name of Physician _____City _____Phone _____
   b. Date of last medical exam _____ Do you have a current medical problem? **YES NO**
   If yes, please state _____
5. Have you been a patient in the hospital for any operation or illness within the past 5 years? _____ YES **NO**
6. Are you allergic to (i.e., itching, rash, and swelling) or made sick by any of the following medications? _____YES **NO**

If so please circle all that apliy:

Aspirin	Local Anesthetic	Percodan	Vicodin
Erythromycin	Penicillin	Tetracycline	Valium
lidocaine or Marcaine	Sleeping Pills	Demoral	
Scopolamine	Darvon	Nitrous Oxide	
Codeine	Nembutal/Seconal	Other Antibiotics	

7. Have you taken any medicine or drugs, including weight reduction medication and herbal supplement, during the past two years? _____ YES **NO**
Please list: _____
8. Do you have or have you had any of the following diseases or problems? Please circle:

AIDS/HIV Positive	Diabetes	Low Blood Pressure	Sickle Cell
Anemia	Emphysema	Kidney Trouble	Disease/Traits
Arthritis	Epilepsy/Seizures	Liver Disease	Sinus Trouble
Artificial Joint	Heart Attack/Disease	Mitral Valve Prolapse	Stroke
Artificial Heart Valve	Heart Failure	Nervousness	STD or VD (Syphilis,
Asthma	Heart Murmur	Pain in Jaw Joints	Gonorrhea)
Chemotherapy (Cancer,	Heart Pacemaker	Psychiatric Treatment	Thyroid Disease
Leukemia)	Hepatitis A (Infectious)	Rheumatic Fever	Tuberculosis (TB)
Congenital Heart-	Hepatitis B (Serum)	Scarlet Fever	
Defects/Lesions	High Blood Pressure		

9. Do you have a disease, condition, or problem not listed above that you think I should know? _____ YES **NO**
If yes, please explain: _____
10. FOR WOMEN ONLY: ARE YOU PREGNANT?_____ YES **NO**
If YES, what month? _____ Are you taking birth control pills? _____ YES **NO**

Authorization:

1. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.
2. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. All procedures have risks, these include, but not limited to: Drug reactions/side effects, damage to adjacent teeth or fillings, post operative sensitivity to temperature and/or pressure, bruising/pain/swelling, failure of dental procedure, necessitating additional treatment, complications during treating necessitating referral to a specialist.
3. I authorize and consent to any x-rays, examination, anesthetics, sedative, or dental treatment rendered for myself and/or children under the general, direct, or indirect supervision of Dr. Farhad Hakim D.D.S.
5. I understand that diagnostic radiographs are necessary to ensure optimum dental health. I will not hold Dr.Farhad Hakim D.D.S. liable for any failure to diagnose or any misdiagnosis due to my refusal for recommended x-rays. I will take full responsibility for any conditions relating to my dental health that may not have been diagnosed or misdiagnosed due to lack of radiographs.
7. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering insurance benefits.

Herndon Dental Center
Farhad Hakim, D.D.S.
625 Elden St., Suite 201
Herndon, VA 20170

8. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.
9. I attest to the accuracy of the information on this page.

PATIENT_ _____ DATE_____
PARENT OR RESPONSIBLE PARTY_____
RELATIONSHIP TO PATIENT_____

Financial Policy

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

We accept the following forms of payment: Cash, Check, Visa, American Express, Discover and MasterCard.

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist.

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Most benefits will be verified before your insurance company can be billed.

All insurance co-pays and deductibles must be paid at the time of service.

We would be happy to discuss our charges and how they relate to your particular situation. We

also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Missed Appointments

Once an appointment has been made, please remember that this time has been reserved specifically for you. We reserve the right to charge a fee of $25 per ½ hour for all cancelled or missed appointments without 48 hours notice.

Specialty Services

A 25% deposit is due at time of appointment scheduling for all surgical and sedation procedures.

Service Charges

The policy of this office is to charge 1% monthly interest (12% annual percentage rate) or a billing charge that will be applied to all accounts over 90 days past due. We will charge $40 for returned checks.

Collection Fees

Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party:_____
Date:_____

Statement of Privacy Practices

We at Herndon Dental Center are dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensuring that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices, but will always inform you of any changes that might affect your rights.

Protecting Your Personal Health Care Information
We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Virginia. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone—even family members—without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access, and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information
We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information
As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointment including voicemail messages, answering machines, and postcards.

Patient Rights
You have a right to request copies of your health care information; to request copies in a variety of formats; and to request a list of the instances in which we, or our business associates, have disclosed your protected information for uses other that those stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient of Herndon Dental Center. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the Herndon Dental Center. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health care information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in this facility.

Herndon Dental Center reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.		
ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY	YES	NO
OTHER (please specify)	YES	NO

_____ _____

Name of Patient or Personal Representative Signature of Patient or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

Office Use Only Below This Line

Record of Acknowledgement Not Obtained		
Provided prior to treatment?	YES	NO
Date Provided _____		
Reason for Denial:	__Needed more time to review Statement of Privacy Practices __Wanted to consult with another person before signing __Reason not given	

__Other (explain)