Fairfax Dental Esthetics
Dr. Sanae Berrada & Dr. Sandra Glikman
9621 Fairfax Blvd. Fairfax, VA 22031
P# 703-279-3400

WELCOME TO FAIRFAX DENTAL ESTHETICS, PLLC

WE'D LIKE TO GET TO KNOW YOU BETTER! THESE FILES ARE CONFIDENTIAL

REGISTRATION INFORMATION

Name_____ Today's Date_____

Home Address_____City_____State____ Zip_____

Home Phone_____ Date of Birth_____ Age_____ Sex- M F

Business Phone_____ Employed by_____

Cell Phone_____ E-mail_____

Occupation_____ SSN_____

Business Address_____City_____Zip_____

Marital Status - ___ Married ___Single ___Divorced ___Separated ___Widowed

If other than above, who will be responsible
for this account?(relationship)_____

Physician (name, phone, location) _____

In case of emergency, contact _____

How did you hear about our office? (Referred by)_____

Date of last dental visit_____

Purpose of today's visit. Remarks: _____

FINANCIAL INFORMATION

Fees are due and payable upon completion of each visit unless other written arrangements are made in advance. We accept cash, Checks, Visa, AMEX, Discover and MasterCard. If you have dental insurance, we will process and submit an initial standard insurance claim form for you as a courtesy. Please provide us with complete and accurate information. If you have insurance, or you are a member of a PPO Dental plan, the co-payments or reduced fee will be accepted only if your insurance eligibility is confirmed in advance of treatment. All fees are estimates only. Final fees are subject to change and insurance company terms and conditions. It is your responsibility that all fees be paid.

Name of insurance company (primary)_____ Policy #_____ Group #_____

Name of subscriber (policy holder) _____ Date of Birth_____ SSN_____

Visa/MC/AMEX Card# _____ Exp. Date_____ Ins Co.#_____

Charges that will be made to you may include:
$10 per month for accounts over 30 days past due. For any returned checks, there will be a $45.00 fee.

$50 per broken appointment unless 48 hours notice is given

$50 for X-ray or record duplication.

Please feel free to discuss your dental treatment and financial concerns.

I hereby understand and grant authority to administer treatment or anesthetics and to perform such operations or procedures as may be deemed necessary or advisable in my diagnosis and treatment. Registration, and medical and dental questions have been understood and answered to the best of my ability and knowledge. I further accept the financial obligations of my, or my dependent's treatment.

Patient or Guardian Signature _____ Date_____

Name: _____ Date: _____

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Medical and Dental History

We ask the following medical and dental history questions to insure safe treatment. Please, indicate your response to each question with a check mark. If you are unsure of the answer, leave the blank. Keep us informed of any changes in your health.

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Yes	No		Yes	No	
		Are you in good health?			Cancer? **List**_____
		Do you take any medicine, pills, drugs?(**list**)			Any Tumor or Growth? (**circle one**)
		_____			Blood Disorder or AIDS? (**circle one**)
		_____			X-Ray treatments?
		_____			Glaucoma or eye trouble?
		Are currently under treatment by a physician? (**please explain**)_____			Do you wear contacts or glasses?
		_____			Trouble hearing?
					Nervous problems?
		Have you ever had an unusual reaction or are you allergic to any medication (Penicillin, Codeine, Novocain, Aspirin)? List_____			Mental illness?
					Do you smoke?
					Sexually transmitted disease? **List**_____
		_____			(Women) Are you pregnant?
		Are there any foods you do not eat? (**list**)			Are you on a diet?
		_____			
		A serious illness or major operation?			Do you exercise regularly?
		Trouble walking, sitting or lying down?			Are you bothered with tooth sensitivity? (cold, Pressure?) _____
		High Cholesterol?			
		Do you have high or low blood pressure?			Do you have any problems eating or swallowing?
		Any bleeding problem or on blood thinner?			Do your gums bleed when brushing or flossing?
		Anemia?			Have you ever had any injury to your face or jaw?
		Rheumatic Fever?			Do you grind or clench your teeth?
		Heart Murmur or Heart Valve Defect?			Does your jaw ever get “out-of-joint” clicks or pop?
		Heart Diseases?			Are you aware of any swelling, rushes, lumps, white patches in your mouth?
		Frequent Headaches?			
		Epilepsy?			Are you unhappy with your smile or teeth color?
		Circulation problems?			Do you have breath problems or mouth odors?
		Hepatitis, jaundice or liver disease? (**circle one**)			Do you fear dental treatment?
		Tuberculosis or lung disease? (**circle one**)			Have you ever had braces, orthodontics?
		Asthma, hay fever, sinus trouble?(**circle one**)			Root canal therapy?
		Stomach trouble , ulcers? (**circle one**)			Gum treatment?
		Kidney Disease?			Nitrous Oxide (laughing gas)?
		Diabetes?			Been put to sleep for dental treatment?
		Do you require medication prior dental treatment? (antibiotics)			Any unusual dental experience? (**please explain**)
		Thyroid Disease?			_____
					_____

Preferred Pharmacy_____ Phone_____

Please add additional information about your medical or dental health, past or present that might aid in your treatment _____

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Written Financial Policy

Thank you for choosing Fairfax Dental Esthetics, PLLC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard or Discover Card
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Fairfax Dental Esthetics requires payment prior to the completion of your treatment.

For plans requiring more than 2 appointments, alternative payment arrangements may be provided.

We also offer in-house financing for treatments over $1000.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 48-hour notice.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I, _____ Date _____
do hereby consent and acknowledge my agreement to the terms set forth in the WRITTEN FINANCIAL POLICY FORM and any subsequent changes in the office policy after giving patient consent. I understand that this consent shall remain in force from this time forward.

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P: (703) 279-3400 F: (703)272-7726
E-Mail: fairfaxdentalesthetics@gmail.com

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[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1-Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2-It is the policy of this office to remind patients of their appointments. We may do this be telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to the office policy and new technology that you might find valuable or informative.

3-The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4-You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurances payers in normal performance of their duties.

5-You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6-Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7-We agree to provide patients with access to their records in accordance with state and federal laws.

8-We may change, add delete or modify any of these provisions to better serve the needs of both the practice and the patient after giving patient notice.

9-You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to confirm to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in the office policy. I understand that this consent shall remain in force from this time forward.

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