Welcome to our practice! 2018

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely. If you have any questions, we'll be glad to help. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date: _____

SS # : _____

Patient Name: _____
Last Name

_____
First Name **Middle Initial**

Address: _____
City: _____
State: _____ **Zip-code:** _____
E-Mail: _____

Sex: □ **M** □ **F** **Age:** _____
Birth date: _____

□ **Married** □ **Widowed** □ **Single** □**Minor**

□ **Separated** □ **Divorced** □ **Domestic Partner**

Occupation: _____
Patient Employer/School: _____
Employer/School Address: _____
_____
Employer/School Phone: (**)**_____
Spouse's Name: _____
Spouse's Birth date: _____
Spouse's SS#: _____
Spouse's Employer: _____
Whom we may thank for referring you?
_____

DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to patient? _____
Insurance Company? _____
Group #: _____

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

If yes…
Subscriber's Name: _____
Birth date: _____ **SS#:** _____
Relationship to patient: _____
Insurance Company: _____
Group #: _____

ASSIGNMENT AND RELEASE:
I certify that I and/or my dependent(s), have insurance coverage with

_____ **and assign directly to**
Name of Insurance Company(ies)

Dr. Hooshangi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Responsible Representative

_____
Printed Name

_____
Date **Relationship to Patient**

PHONE NUMBERS

Home: (**)**_____ **Work: (** **)**_____**ext**_____ **Cell: (** **)**_____
Spouse's Work: (**)**_____**ext**_____ **Best time and number to reach you:** _____
IN CASE OF EMERGENCY CONTACT PERSON:
Name: _____ **Relationship:** _____
Home Phone: (**)**_____ **Work Phone: (** **)**_____**ext**_____

DENTAL HISTORY

Reason for today's visit: _____
_____
Former Dentist: _____
Date of last dental visit: _____
Date of last dental X-rays: _____
Place a mark on "Yes" or "No" to indicate if you had any of the following:

Bad breath	□ Yes □ No	**Chew on one side of mouth**	□ Yes □ No	**Mouth Breathing**	□ Yes □ No
Bleeding gums	□ Yes □ No	**Cigarette, Pipe or Cigar Smoking**	□ Yes □ No	**Mouth Pain**	□ Yes □ No
Blisters on lips or mouth	□ Yes □ No	**Clicking or Popping Jaw**	□ Yes □ No	**Orthodontic Treatment**	□ Yes □ No
Burning sensation	□ Yes □ No	**Dry Mouth**	□ Yes □ No	**Pain around ear**	□ Yes □ No
		Fingernail biting	□ Yes □ No	**Periodontal Treatment**	□ Yes □ No
		Food collection between teeth	□ Yes □ No	**Sensitivity to cold**	□ Yes □ No
		Foreign objects	□ Yes □ No	**Sensitivity to heat**	□ Yes □ No
		Grinding Teeth	□ Yes □ No	**Sensitivity to sweets**	□ Yes □ No
		Gums swollen or tender	□ Yes □ No	**Sensitivity when biting**	□ Yes □ No
		Jaw pain or tiredness	□ Yes □ No	**Sores or growth in mouth**	□ Yes □ No
		Lip or cheek biting	□ Yes □ No	**How often do you floss?** _____	
		Loose teeth or broken fillings	□ Yes □ No	**How often do you brush?** _____	

HEALTH HISTORY

Primary 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 Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine): □ Yes □No

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	□ Yes □ No	Epilepsy	□ Yes □ No	Radiation Treatment	□ Yes □ No
Anemia	□ Yes □ No	Fainting or Dizziness	□ Yes □ No	Respiratory Disease	□ Yes □ No
Arthritis, Rheumatism	□ Yes □ No	Glaucoma	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Artificial Heart Valves	□ Yes □ No	Headaches	□ Yes □ No	Scarlet Fever	□ Yes □ No
Artificial Joints	□ Yes □ No	Heart Murmur	□ Yes □ No	Shortness of Breath	□ Yes □ No
Asthma	□ Yes □ No	Heart Problems	□ Yes □ No	Sinus Trouble	□ Yes □ No
Back Problems	□ Yes □ No	Hepatitis Type_____	□ Yes □ No	Skin Rash	□ Yes □ No
Bleeding abnormally with		Herpes	□ Yes □ No	Special Diet	□ Yes □ No
extractions or surgery	□ Yes □ No	High Blood Pressure	□ Yes □ No	Stroke	□ Yes □ No
Blood Disease	□ Yes □ No	Jaundice	□ Yes □ No	Swollen Feet or Ankles	□ Yes □ No
Cancer	□ Yes □ No	Jaw Pain	□ Yes □ No	Thyroid Problems	□ Yes □ No
Chemical Dependency	□ Yes □ No	Kidney Disease	□ Yes □ No	Tonsillitis	□ Yes □ No
Chemotherapy	□ Yes □ No	Liver Disease	□ Yes □ No	Tuberculosis	□ Yes □ No
Circulatory Problems	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Tumor growth on head or neck	□ Yes □ No
Congenital Heart Lesions	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No	Ulcer	□ Yes □ No
Cortisone Treatment	□ Yes □ No	Nervous Problems	□ Yes □ No	Venereal Disease	□ Yes □ No
Cough, persistent or bloody	□ Yes □ No	Pacemaker	□ Yes □ No	Unexplained weight loss	
Diabetes	□ Yes □ No	Psychiatric Care	□ Yes □ No	or gain	□ Yes □ No
Emphysema	□ Yes □ No				

Do you wear contact lenses? □ Yes □ No

WOMEN:

Are you pregnant? □ Yes □ No **If so, please provide us your due date:** _____

Taking birth control pills? □ Yes □ No **Are you nursing?** □ Yes □ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name: _____

Phone #: ( ) _____

ALLERGIES

□ Aspirin
□ Barbiturates (Sleeping pills)
□ Codeine
□ Iodine
□ Latex
□ Local Anesthetic
□ Penicillin
□ Sulfa
□ Other _____

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever has a change in health.

I certify that I, and/or my dependent(s) have insurance coverage with _____ **and assign directly to**

Name of Insurance Company(ies)

Dr. Hooshangi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submission.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Printed Name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**

Mitra Hooshangi, D.D.S, LLC

2112 Gallows Road, Vienna, VA 22182 Suite D
703-893-7900

Office Policies and Procedures

Welcome to Dr. Mitra Hooshangi, DDS dental practice in Vienna, Virginia. To help us better serve you, please read this document carefully and sign below. Thank you!

1. Payment in full is due at time of service unless previous arrangements are made. We accept cash, checks, and credit cards.
2. There is a **$35.00 returned check charge each time a check is returned for any reason**.
3. Balances 30 days past due are subject to a **10% financing charge**. If this account is turned over to our attorney or collection agency after 90 days, you agree to all collection fees including court costs and added interest from the initial statement date.
4. Your appointment time is reserved exclusively for you. We require 24-hour notice for all cancellations. **There is a $45.00 charge for any or all missed appointments without a 24-hour notice.**

For our Insured Patient:

5. As a courtesy, we will attempt to verify basic plan information and estimated co-pays. Verification is not a guarantee of payment by the insurance company or a release of the patient's legal obligation for bill payment.
6. Your estimated deductible and co-pays are due in full at time of service. After your insurance has determined and paid its share of Dental benefits, any difference between the estimated and actual amount due will be billed to you.
7. As your Dental specialist, it is our responsibility to provide you and your family with the best possible dental care. Please remember, your insurance policy is between you and your company, and not between the insurance company and your doctor.
8. If you arrive without your insurance card or ID, you will accept full responsibility for all costs incurred. The broken appointment charge will be waived if you are rescheduled for an office visit at a later date.
9. As a courtesy, we will file your claim to your primary insurance company. To authorize payment to our dental practice, your insurance may require appropriate referral for a specific procedure. Please make sure we have all the appropriate documentation, your insurance company might not pay the claim, and you are responsible for full payment for the treatment.

If there is anything we can do to make your dental visit more enjoyable please feel free to let us know. We are committed to provide personal and excellent care to you and your family in a patient friendly environment.

Our Office Manager will be happy to help you and answer any questions and/or concerns you may have.

Your signature indicates that you have read, understand, and agree to the terms and conditions set forth above.

Signature:_____ Date: _____

Printed Name:_____

Patient Name:_____

Relationship to Patient: _____

Office Staff Member: _____

Mitra Hooshangi, D.D.S, LLC

2112-D Gallows Road, Vienna, VA 22182
703-893-7900

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Dr. Mitra Hooshangi, DDS, Dental Practice, we have always kept your health information secure and confidential. A new law requests us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your case.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. We may share your medical/dental information with our business associates, such as a billing service. We have a written contract with each business associate that requests them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters, post cards, or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care.We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to transfer copies of your health information to another practice. We will mail your files for you after signed consent by you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment of change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the **Department of Health and Human Services**
200 Independence Avenue, SW, Room 509 F
Washington, DC 20201

You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at 703-893-7900.

This notice goes into effect as of July 11, 2004.

ACKNOWLEDGEMENT

I have received a copy of the Dr. Mitra Hooshangi, DDS Dental Office Notice of Privacy Practice and a signed copy will go into my records.

Patient: _____ Date: _____

Patient/Guardian Signature: _____

Print Name: _____

If signing as a parent or guardian, please note the name of the Patient.

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a $_35___ returned check fee. Any account balances that remain unpaid for __90_ days from the date of service shall accrue interest at the rate of _20__ percent (_20_%) per year and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of $__25___. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

PatientSignature: _____ Date: _____

Print Name: _____

Guardian/Responsible Party, if minor:_____ Date: _____

Print Name: _____