ALBERT
FAMILY DENTISTRY
GENERAL • COSMETIC • RESTORATIVE

Thank you for trusting Albert Family Dentistry to be your dental home. We look forward to getting to know you and your family!

Patient Information

Name (First/Middle/Last): _____ DOB: _____

Age: ____ SSN: _____ Address: _____

Phone: (Cell)_____ (Home)_____ (Work)_____

Employer: _____ Personal Email: _____

Emergency Contact Name and Phone: _____

Insurance ** A Copy of your Dental Insurance Card and Photo ID is REQUIRED**

Policyholder Name: _____ DOB: _____Group #: _____ ID #: _____

Policyholder Employer: _____ Relationship to Policyholder: ( ) Self ( ) Spouse ( ) Child

Policyholder SSN: _____ Dental Insurance:_____ Secondary Insurance: _____

Referral

How did you hear about our practice?

( ) Family____ Friend____ Co-Worker____ (Whom may we thank?):_____

( ) Insurance Website

( ) Internet Search: Google____ Facebook____ Nextdoor____

( ) Other: _____

Contact Preference

What is your preference for our office to communicate with you:

( ) Text Message on Cell Phone

( ) Email

( ) Phone Call (Cell, Home, or Work)

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Dental History

1. What brought you to our dental office? _____

2. What approximate date was your last dental exam/cleaning? _____

3. Are you currently having dental pain? Yes No Where?_____

4. Do you have any cosmetic concerns that you would like addressed?

   Crooked teeth Color Silver fillings Spaces Staining Other_____

5. Are you interested in our dental whitening options? Yes No

6. Are you interested in Invisalign orthodontic treatment? Yes No

7. Do your gums ever bleed when you are brushing? Yes No

8. Do you clench or grind at night? Yes No If yes, do you wear a night guard? Yes No

9. For children 13yrs and younger: Do you have (fluoridated water supply) or (well water)? Circle one

10. Do you have/wear dentures or partials? Yes No

11. Do you take pre-medication for dental appointments? Yes No

12. Why did you leave your previous dentist? _____

13. Did your previous dentist discuss/mention areas of concern in your mouth? _____

14. May we call your previous office for X-rays? Yes No Office name/phone number_____

Financial Policy

We accept most dental insurances and are in-network providers with many local plans. If you have dental insurance, we will provide you with an **estimate** of the insurance company's expected coverage as well as your co-payment. All co-payments are due **at the time of service**. When our office receives the insurance payment and explanation of benefits, you will be responsible for any remaining balance. Any overpayments will be credited to your dental account with us or refunded to you. Our office does not guarantee that your insurance company will pay for the treatment received at our dental practice. If your claim is denied, you will be responsible for the full balance of treatment.

If you do not have dental insurance, complete payment for treatment will be required at the time of service. Overdue accounts may be turned over to a collection agency in which you will legally be responsible for any costs associated with collections i.e. court costs, attorney fees, etc.

Appointment Policy

Out of respect for the doctor, staff, and other patients' time; kindly give us a **48 hours** notice if you need to cancel or re-schedule your appointment. If **less than 24 hours** notice is given, you will be charged a **$50 fee**.

_____ _____

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

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Notice of Privacy Practices Consent

I understand that under the Health Insurance Portability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information and that Albert Family Dentistry may use or disclose my protected health information for treatment, payment, or health care operations--which means for providing health care to me, the patient, handling billing and payment, and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Albert Family Dentistry has a detailed document called the "**Notice of Privacy Practices'.** It contains a more complete description of your rights to privacy and how we may use and disclose protected health information. **I understand** that I have the right to read the 'Notice' before signing this agreement. If I ask, Albert Family Dentistry will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Albert Family Dentistry to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Albert Family Dentistry has taken action relying on this consent.

_____ _____

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

_____ _____

Relationship to Patient if signed by another party **DATE**

Authorization to Disclose Protected Health Information

Under requirements of HIPAA, we are not allowed to give medical/dental information to anyone without the patient's consent. If you wish to have your medical/dental information released to family members or friends, list the individual(s)

Name: _____ Phone: _____ Relationship:_____

Name: _____ Phone: _____ Relationship:_____

Notice of Deemed Consent for HIV, HBV, and HCV Testing

If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with HIV, Hepatitis B and C viruses. A Physician or other healthcare provider will tell you the results of that test. Under Virginia Code 32.1-45.1 you are deemed to have consented to the release of the test results to the person exposed. I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

_____ _____

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

_____ _____

Relationship to Patient if signed by another party **DATE**

Time 1:11 PM | Kevin Albert, D.D.S. | Date 9/29/2017

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

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Request for Release of Dental Records

Name of Patient: _____

Date of Birth: _____

Other Family Members to Transfer (Names & Dates of Birth) : _____

_____

_____

Previous Dentist: _____

City/State: _____ Phone Number: _____

Please forward any x-rays, probing depth charts, charting, and photographs to:

Albert Family Dentistry
90 Whitewood Rd Suite 3
Charlottesville, VA 22901
info@albertfamilydentistry.com

I hereby give permission to release any and all of my dental records to Albert Family Dentistry.

_____ _____

Patient Signature Date

By signing this form, I consent to use Electronic Records and Signatures