Please indicate for whom we will be providing care: | BIRTHDATE

How did you hear about our office:

There is additional information requested below for this patient and the responsible party, if different. Please provide the confidential information in the appropriate areas. Your assistance and cooperation are appreciated.

PATIENT OR RESPONSIBLE PARTY, IF PATIENT IS A MINOR

TITLE FIRST NAME INITIAL LAST NAME	SSN	BIRTHDATE	HOME PHONE
STREET ADDRESS	CITY	STATE	ZIP
EMPLOYER	OCCUPATION		WORK PHONE
BUSINESS ADDRESS	CITY	STATE	ZIP
EMAIL ADDRESS			CELL PHONE

SPOUSE

TITLE FIRST NAME INITIAL LAST NAME	SSN	BIRTHDATE	HOME PHONE
STREET ADDRESS	CITY	STATE	ZIP
EMPLOYER	OCCUPATION		WORK PHONE
BUSINESS ADDRESS	CITY	STATE	ZIP

CHILD (IF CHILD IS THE PATIENT)

FIRST NAME INITIAL LAST NAME	SSN	BIRTHDATE	HOME PHONE
STREET ADDRESS	CITY	STATE	ZIP
SCHOOL	GRADE		SEX: M F

DENTAL INSURANCE

PRIMARY INSURANCE COMPANY	SSN	ID NUMBER	GROUP NUMBER
STREET ADDRESS	CITY	STATE	ZIP
SECONDARY INSURANCE COMPANY	SSN	ID NUMBER	GROUP NUMBER
STREET ADDRESS	CITY	STATE	ZIP

CREDIT CARD INFORMATION

For your convenience, we will apply any unpaid balance to this credit card.

CARD TYPE	ACCOUNT NUMBER	NAME ON CARD	EXPIRATION DATE

CONSENT FOR TREATMENT: As the undersigned, I hereby authorize Richard E. Livesay, D.D.S., Joseph P. Fusaro, D.D.S., Carl W. McCrady, PhD D.D.S. and/or Dr. Jamie Johnson D.D.S. **(THE DOCTORS)** and the Fredericksburg Dental Care staff to, after thorough explanation, take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by **THE DOCTORS** to make a diagnosis of my or my dependent's dental needs. I also authorize **THE DOCTORS** to perform any and all forms of treatment, medication and therapy that may be indicated (after they are discussed with me) and further authorize and consent that **THE DOCTORS** choose and employ such assistance as they deem fit. I also understand the use of anesthetic agents embodies a certain risk.

CONSENT FOR INFORMATION RELEASE AND ASSIGNMENT: I authorize **"RELEASE OF MEDICAL INFORMATION"** for insurance purposes by **THE DOCTORS**. The required **"ASSIGNMENT OF BENEFITS"** is noted and I authorize payment directly to **THE DOCTORS** as listed for any treatment received by myself and/or any dependents. I acknowledge and understand that payment is due at the time of treatment and I accept full financial responsibility for any and all charges not covered by **"ASSIGNMENT OF BENEFITS."**

CONSENT FOR FEE ASSOCIATED WITH NON-PAYMENT: In the event of non-payment and/or a returned check, I agree to pay any and all costs of collection, including **1.5%** interest per month on any unpaid balance, any and all court costs, **33.3%** attorney fees and/or a Returned Check Fee of **$35.00**. In the event, treatment requires a series of visits, I understand that a request for any available credit history may be initiated. All the information obtained will be held in strict confidence and will not be disseminated to any individual. A fee may be charged for this service.

Date | Relationship to Patient

Responsible Party Signature

1. Are you in good health?			YES	NO
2. Has there been a change in your general health?			YES	NO
3. Are you under the care of a physician?			YES	NO
If so, what condition is being treated?				
PHYSICIAN'S NAME			OFFICE PHONE	
ADDRESS	CITY	STATE	ZIP	
4. Have you been hospitalized or had a serious operation/illness in the past 5 years?			YES	NO
5. Do you have/have you had any of the following diseases/problems? Please circle all that apply.				

Heart Failure	Diabetes	Emphysema	Hepatitis/specify type:	Heart Surgery
Liver Disease	Thyroid Disease	Fainting/Dizziness	Artificial Heart Valve	Mitral Valve Prolapse
Angina Pectoris	Yellow Jaundice	Tuberculosis (TB)	Congenital Heart Lesions	Cold Sores
Cancer	Chemotherapy	Asthma	X-ray or Cobalt Treatment	Ulcers
Sickle Cell Anemia	Arthritis	Sinus Trouble	STD/VD (Syphilis/Gonorrhea)	Kidney Trouble
HIV Positive	Cortisone Medicine	Allergies or Hives	Heart Disease or Attack	AIDS
Bruise easily	Heart Murmur	Glaucoma	High Blood Pressure	Hay Fever
Scarlet Fever	Rheumatic Fever	Artificial Joint	Pain in Joint of the Jaw	Heart Pacemaker
Blood Transfusion	Epilepsy/Seizures	Anemia	Psychiatric Treatment	Stroke

6. Are you taking any drug or medicine (this would include FOSAMAX)?	YES	NO
If so, please list:		
7. Are you allergic or have you reacted adversely to any drug or medicine?	YES	NO
If so, please list:		
8. When you walk, do you have to stop due to pain in your chest?	YES	NO
9. Have you had serious trouble associated with previous dental treatment?	YES	NO
If so, please explain:		
10. Have you had abnormal bleeding associated with dental treatment?	YES	NO
11. Do you have a disease/condition/concern not listed you think I should know?	YES	NO
If so, please explain:		
12. FOR WOMEN ONLY - ARE YOU PREGNANT? Please indicate what month_____	YES	NO
13. FOR WOMEN ONLY - Are you taking birth control pills?	YES	NO

Person to contact in case of emergency

NAME	RELATIONSHIP		PHONE
STREET ADDRESS	CITY	STATE	ZIP

Signature

Date	Patient/Responsible Party Signature	Relation to Patient

Doctor's Notes

Date Reviewed:	Reviewed by:

FREDERICKSBURG DENTAL CARE

Please fill out this questionnaire so the doctors and staff will be able to identify and address all concerns you may have regarding your dental health.

Did a specific problem or concern prompt your visit with us today? YES NO
If so, please describe: _____
Can you approximate the last time you saw a dentist for a dental cleaning? _____yrs.
Why did you leave your last dentist? _____
How often do you brush your teeth? ___/per day. Do you floss regularly YES NO
Do you drink carbonated or sport drinks? YES NO (# per day_____)
If you are missing teeth, are you interested in replacing them? YES NO N/A
Would you like to keep your teeth for the rest of your life? YES NO
Are you happy with the appearance of your smile? YES NO
If not, what would you like to see improved: _____

(AREA BELOW FOR DOCTORS NOTES)

_____
_____
_____
_____
_____

Did you know that periodontal (gum) disease is painless? It affects 75% of the population and often victims are unaware of its existence. In this day and age prevention is key and periodontal disease could be a catalyst for other diseases to manifest in your body. Researchers have established a link between your oral health and other medical diseases, such as heart disease which may be affecting your overall health. There are certain warning signs of periodontal disease. The following questions may establish if you are at risk.

Do your gums bleed when you brush or floss your teeth? YES NO
Are your gums red, swollen or tender? YES NO
Are your permanent teeth loose or separating? YES NO
Do you smoke or use any tobacco products? YES NO
Do you suffer from persistent bad breath? YES NO
Did either of your parents lose their teeth at an early age? YES NO
Are your gums pulling away from your teeth? YES NO

If you answered yes to any of these questions then you may suffer from a form of periodontal disease. One portion of your exam today will consist of a complete periodontal exam which will enable us to gauge your current status of periodontal health and more importantly what needs to be done to ensure you maintain your teeth for a lifetime.

Is snoring an issue for you? YES NO
Have you been diagnosed with sleep apnea? YES NO
If yes, do you use a sleep apnea appliance? YES NO
Do you suffer from any dental phobias? YES NO

If yes, and this is a concern for you, you will be pleased to know that we can offer you Nitrous Oxide, Oral or IV sedation. Please be sure to speak to your doctor about all the sedation options available to you and which one may be best for your needs.

Have you had your wisdom teeth (3rds molars) removed? YES NO
How did you hear about our practice? _____
Is there someone we can thank for referring you to our office? _____
_____

Are there any current events in your life such as an upcoming significant event, a financial burden or stress that would impact how dentistry may fit into your life at this time? If so, please describe. Use back of paper if necessary.

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of the 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 your treatment, payment, and healthcare operations.
For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider 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, conduction training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of 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 is in effect. Unless you give us 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 Patients 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.

Persons Involved In Care: We may use and disclose your 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 the 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 without your written authorization.

REQUIRED BY LAW: We may use and 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 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 inc=mate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use and disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

FREDERICKSBURG DENTAL CARE

COSMETIC, SEDATION, IMPLANT, FAMILY & GENERAL DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please print name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____

_____

FREDERICKSBURG DENTAL CARE

COSMETIC, SEDATION, IMPLANT, FAMILY & GENERAL DENTISTRY

PATIENTS CONTACT AUTHORIZATION

I, _____, hereby authorize Fredericksburg Dental Care to discuss my care and/or appointment reminders with the following persons:

1. _____

2. _____

3. _____

4. _____

5. _____

MAY WE LEAVE A DETAILED MESSAGE ON YOUR ANSWERING MACHINE REGARDING YOUR CARE?

YES OR NO

Signature _____

FREDERICKSBURG DENTAL CARE

COSMETIC, SEDATION, IMPLANT, FAMILY & GENERAL DENTISTRY

OFFICE POLICY REGUARDING INSURANCE ASSIGNMENT

Our office is pleased to accept insurance assignment as soon as your coverage is verified with your insurance company. We will file your claim forms when provided with the appropriate information and assist you in every way we can.

However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

Our office policy with regards to assignment is as follows:

-This is a courtesy that may be withdrawn if your insurance company becomes uncooperative in making payments.

-You agree to pay your **ESTIMATED** co-pay (if applicable) prior to treatment.

-You are required to sign an "Authorization To Pay Physician" form and any other assignment documents required by your insurance company.

-Our office **DOES NOT** guarantee that your insurance will pay. We will make every attempt at the beginning of your treatment to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the fill amount of your bill.

- Should a dispute arise with your insurance company over your claim, or no payment has been received within 45 days, you will be responsible for contacting your insurance company. We will provide you and your insurance company with all necessary information to process your claim.

_____ _____

(Signature) (Date)

_____

(Print Name)