Winchester DENTAL STUDIO
Where wellness matters...

First Name: _____ Last Name: _____

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

Home Phone: _____ Work Phone: _____

Cell: Phone: _____ Pager: _____

Email: _____

Sex: ¦ Male ¦ Female Marital Status: ¦Married ¦Single ¦Divorced ¦Separated ¦Widowed

Date of Birth: _____ Social Security #: _____

Employer: _____ Employer Address: _____

Employment Status: ¦ Full Time ¦ Part Time ¦ Retired Student Status: ¦ Full Time ¦ Part Time

Name of Emergency Contact: _____ Emergency Contact Phone_____

_____Patient Preferences_____

Do you prefer ¦Morning Appointments? ¦Afternoon Appointments?

What's your preferred method of us contacting you? ¦ Phone ¦Email

_____How did you hear about us? _____

¦ Referred by a friend or relative If yes, who? _____
¦ Our Website (www.winchesterdentalstudio.com)
¦ Facebook, Groupon, or other social media
¦ Print Advertising
¦ Other: _____

_____Patient Responsibility_____

Who is responsible for your accounts? ¦ Self ¦Spouse ¦Parent ¦Other

If not your self: Responsible party's name: _____ Date of Birth: _____

Employer: _____ Work Phone: _____

Social Security #:_____

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

_____Insurance_____

Do you have Dental Insurance? ¦ No ¦Yes ¦Insurance Co Name: _____

Subscriber: _____ Relationship to Patient: ¦ Self ¦ Spouse ¦Parent ¦Other

Subscriber's Employer: _____ Social Security #:_____

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DENTAL HISTORY

1. Reason for your visit? _____
2. When was your last dental visit? _____
3. How often do you brush? _____
4. Do you use a manual or electric tooth brush? _____
5. What texture brush do you use? _____
6. Do your gums bleed? ☐ **Yes** ☐ **No**
7. Do you floss? ☐ **Yes** ☐ **No**
8. Do your gums bleed when you flossing? ☐ **Yes** ☐ **No**
9. Do you feel pain to any of you teeth when brushing or flossing? ☐ **Yes** ☐ **No**
10. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? ☐ **Yes** ☐ **No**
11. Have you notice any loosening of teeth ☐ **Yes** ☐ **No**
12. Does food tend to become caught between your teeth? ☐ **Yes** ☐ **No**
13. Do you have any sores or lumps in your near you mouth? ☐ **Yes** ☐ **No**
14. Have you experienced any of the following problems in your jaw?
    a. Clicking? ☐ **Yes** ☐ **No**
    b. Pain (joint, ear, side of face) ☐ **Yes** ☐ **No**
    c. Difficulty in opening or closing? ☐ **Yes** ☐ **No**
    d. Difficulty in chewing? ☐ **Yes** ☐ **No**
15. Have you had any head, neck, or jaw injuries? ☐ **Yes** ☐ **No**
16. Do you have frequent headaches? ☐ **Yes** ☐ **No**
17. Do you bite your lips or cheeks frequently? ☐ **Yes** ☐ **No**
18. Have you ever had:
    a. Orthodontic treatment (Braces or Invisalign) ☐ **Yes** ☐ **No**
       If Yes What Age? _____
    b. Oral surgery? ☐ **Yes** ☐ **No**
    c. Gum Treatment? ☐ **Yes** ☐ **No**
    d. Your teeth ground or the bite adjusted? ☐ **Yes** ☐ **No**
    e. Worn a bite plane or other appliance? ☐ **Yes** ☐ **No**
19. Are you satisfied with the appearance of your teeth? ☐ **Yes** ☐ **No**
20. Is there anything about having dental treatment that bothers you? ☐ **Yes** ☐ **No**
    If Yes, Please explain
    _____
21. If there's anything you'd like to improve regarding your smile what would that be?
    _____

To the Best of my Knowledge, the questions on this form have been accurately answered. I understand that proving incorrect information can be dangerous to my or patient health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____
DATE_____

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ACKNOWLEDGEMENT OF PRIVATE PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of heath care providers who may be involved in the treatment directly and indirectly.
2. Obtain payment from third-party payers for my health care services.
3. Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

1. Pursuant to Virginia Law 32.1-54.1 Any patient who exposes a health care provider or his employee/agent to body fluid in a manner which may transmit the human immunodeficiency virus (HIV), Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis B and C testing and provider who exposes a patient to body fluid in the above stated manner.

Signature: _____ Date: _____
Relationship to Patient: _____
Dependent family members also covered by this acknowledgement

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For office use only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy due to the following reason:

- The Patient refused to sign
- Communication barriers
- Emergency situation

FINANCIAL POLICY

It is the goal of our practice to provide not only the finest care available, but also to provide financial services that do not cause undue hardships. Patients will be scheduled for treatment after financial arrangements are made with our financial department regarding all treatment. OUR FINANCIAL DEPARTMENT IS AVAILABLE TO ANSWER ANY QUESTIONS YOU HAVE.

Our office requires a 24 hour notice if you are not able to make your appointment. If we do not receive this notice, a $50/ per hour fee will be charged to your account.

X-ray Requirements—We pride ourselves in delivering the highest standard of care; therefore, complete diagnostic x-rays are necessary. We require a complete series of x-rays on new patients and patients who have not been to see us on a regular basis. If you have had this series done with another dentist in the past three years, we ask that you bring them with you on your initial visit. **IF YOU DO NOT HAVE THEM OR ARE NOT ABLE TO RETRIEVE THEM FROM YOUR PRIOR DENTIST BEFORE YOUR APPOINTMENT WITH US, WE WILL NEED TO TAKE X-RAYS AND BILL YOU.**

Insurance policy—The patient is always expected to pay his/her portion at the time of service, including co-pay and deductibles. As a courtesy to all of our patients with insurance, we will file dental services with your insurance company. The normal time allowed for insurance response is 30 days. Any charges remaining on your account after your insurance pays are ultimately your responsibility. When the office quotes insurance co-pays, this is an **estimate** only.

Payment Policy—Our office requires payment in full for all services rendered at the time of visit. Payment plans are available and are arranged through our financial department to assist our patients.

Collection policy—If your account becomes delinquent and no financial arrangements have been made, you will be responsible for legal fees, and any other expenses incurred in collecting your account balance. All work must be paid in full at the time of service once your account has been satisfied with the attorney.

AUTHORIZATIONS FROM PATIENT

I authorize Winchester Dental Studio to perform any necessary services needed during diagnosis and treatment. I also authorize the release of any required information to outside health practitioners and for the purpose of processing insurance claims.

I understand that my insurance policy is a contract between my insurance company and me and that I am responsible to Winchester Dental Studio for all fees.

I authorize and request my insurance company (if applicable) to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual billed services and that I am responsible for the remaining balance.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature of Patient/Parent/Guardian of Minor _____

Date_____

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MEDICAL HISTORY

Patient Name _____ Birth date _____

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? O Yes O No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain: _____
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain: _____
Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain: _____
Do you take, or have you ever taken, Phen-Fen or Redux? O Yes O No _____
Are you on a special diet? O Yes O No _____
Do you use tobacco? O Yes O No _____
Do you use controlled substances? O Yes O No _____

Women: Are you: Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics
O Other If other, please explain: _____

Do you have, or have you had, any of the following? (Circle all that apply)

AIDS/HIV Positive
Alzheimer's disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever
Blisters
Congenital Heart Disease
Convulsions
Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting
Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
Cortisone
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain in Jaw Joints
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain: _____

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 dentist of any changes medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____

650 Cedar Creek Grade, Suite 205, Winchester VA, 22601 Phone: (540)323-7063

Photo/ Video Consent

Authorization for use or disclosure of photo/video images
I consent that Winchester Dental Studio may use photographs or videos of me, taken on the date indicated below, on their social media tools which includes but is not limited to their Facebook page. I understand that these images and/or videos will not be used for any other commercial purposes.
Name (please print):

_____
Date: _____
Signature: _____
(If person(s) in photo/videos is a minor, please indicate below)
Name of Minor(s) (please print):

_____
_____
_____
Parent/Guardian Name (please print):

_____
Date:_____
Signature:_____

Authorization: I authorize the use and disclosure of my name, photo/video and or testimonial for
marketing purposes by Winchester Dental Studio. I understand that information disclosed pursuant to this
authorization may be subject to redisclosure and may no longer be protected by HIPPA privacy
regulations.
Revocability: I understand that I may revoke this authorization at any time, but such must be in writing
and received by the practice via registered mail. Revocation affects disclosure moving forward and is not
retroactive. This authorization expires in 99 years from date signed.