Arlington DENTAL EXCELLENCE
3801 N. Fairfax Dr, Suite 54
Arlington, VA 22203
(703)525-0157

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

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

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2 _____ Section 3 _____

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____.00

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

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

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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 Problem ☐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 _____

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 _____ DATE _____

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DENTAL INSURANCE INFORMATION

Insurance Company Name:
Address: Group#
Phone Number: Relationship to Patient:
Insured's Name: Member ID #
Insured's DOB:
Insured'sEmployer:
Employer Address:
FamilyMembers Covered Under my Plan:

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company Name
Address: Group#
Phone Number: Relationship to Patient:
Insured's Name: Member ID #
Insured's DOB:

Insured'sEmployer:
EmployerAddress:
Family Members Covered Under my Plan:

SIGNATURE ON FILE FOR RELEASE AND ASSIGNMENT

I hereby authorize Layth Ghanim, DDS to release to the above listed insurance company, and its representatives, and information including the diagnosis and the records of any dental treatments or examinations rendered to me or to any other member of my family on my plan.

I also authorize and request the above named insurance company to pay directly to Layth Ghanim, DDS the amount due under my plan for dental treatments and services rendered to me or to family members.

I understand that signing on the signature line allows Dr. Ghanim's office to put signature on file on the insurance forms so that I do not have to sign the forms each time I come to the office.

To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and the patient is personally responsible for payment of fees. We will prepare the necessary forms to help the patient obtain the maximum benefits available under his/her policy. We do not render our services on the basis that insurance companies will pay our fees or that the services rendered are covered under the patient's insurance plan.

I understand that I am responsible for payment for fees for dental treatment and services rendered to me or to my family regardless of what my insurance may cover.

SIGNATURE: DATE

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Consent for Treatment, Insurance Assignment, Financial Responsibility

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and my other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my or my dependent's dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required in providing proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I authorize release of any information concerning my own or my dependent's health care for the purpose of evaluating and administering claims for health care benefits. I hereby authorize payment of insurance benefits directly to the doctor. I agree to be responsible for payment of all services rendered on my or my dependent's behalf. I understand that payment is due at the time of service, unless other arrangements have been madea in advance of any services.

I have read the above policies of Arlington Dental Excellence and understand my responsibilities as a patient.

SIGNATURE OF RESPONSIBLE PARTY:

RELATIONSHIP TO PATIENT:

DATE:

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private 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 or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME:

RELATIONSHIP TO PATIENT:

SIGNATURE:

DATE:

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

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Payment Options

I, , have received the Payment Options and Information. I understand that it is my responsibility to read, understand, and ask any questions that I may have regarding the Payment Options and Information. I will abide by my financial obligations to Arlington Dental Excellence.

PATIENT SIGNATURE:

DATE:

FRONT OFFICE ADMINISTRATOR:

DATE:

Click Here to RESET

RESET