



Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

Awesome Smiles Dental Center 6468 Trading Square Haymarket, VA 20169 571-261-2600 (office) 571-261-2699 (fax)
PATIENT INFORMATION

Name [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other:
Address Occupation: [ ] Male [ ] Female
City State Zip Hm# ( )
Employer Wk# ( ) Ext
Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell # ( )
DOB: / / SSN# E-mail @
Spouse's Name First MI Last (if different)
Spouse occupation Work phone Ext
Is patient a full time student? [ ] No [ ] Yes: Name of school:

RESPONSIBLE PARTY (if different than patient)

Name First MI Last
Address
City State Zip
Hm# ( )
Wk# ( )
DOB: / /
SSN#
Relationship:

YOUR PREFERENCES
Do you prefer appointment reminders by:
[ ] Email [ ] Phone [ ] Text
Do you prefer to receive calls from our office at:
[ ] Home [ ] Work [ ] Cell
Whom may we thank for referring you?

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name Relationship to patient:
Subscriber's DOB: / / Subscriber's SSN#
Insurance Company Policy # Group #

SUPPLEMENTAL INSURANCE (DENTAL):

Subscriber's Name Relationship to patient:
Address City State Zip
Subscriber's DOB: / / SSN# Employer:
Insurance Company Group # Eff. Date: / /

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Subscriber's Name Relationship to patient:
Address City State Zip
DOB: / / SSN# Employer:
Insurance Company Group # Eff. Date: / /

## MEDICAL HISTORY and CONSENT

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

### Allergies

Acrylics	Y	N
Anaphalaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

List other known allergies:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Cardiovascular

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

### Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Change	Y	N
Thyroid problems	Y	N

### Eyes, Ears, Nose and Throat

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus (Ringing)	Y	N

### Gastrointestinal

Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

### Genitourinary

Frequent Urination	Y	N
Kidney disease	Y	N
Nocturia	Y	N

### General

Current weight: \_\_\_\_\_ lbs

Height: \_\_\_\_\_ ft \_\_\_\_\_ in

Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/hip replacement	Y	N
Liver problems	Y	N
Recent Trauma or Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Weight Change	Y	N

### Hematological

Bleeding problems	Y	N
Hepatitis	Y	N

### Oral

Bleeding gums	Y	N
Dry mouth	Y	N
Jaw problems (TMJ)?	Y	N
Clicking?	Y	N
Pain?	Y	N
Difficulty swallowing?	Y	N
Difficulty chewing?	Y	N
Orthodontics/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth clenching	Y	N
Teeth grinding	Y	N
Tooth pain	Y	N
Wisdom teeth extraction	Y	N
Do you wear removable teeth?	Y	N

Do you take or need antibiotics before dental procedures? Y N

### Musculoskeletal

Back Pain	Y	N
Fibromyalgia	Y	N

Joint Pain	Y	N
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### Neurological

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

### Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating disorders	Y	N
Excessive Stress	Y	N
Memory problems	Y	N

### Respiratory

Asthma	Y	N
Bronchitis	Y	N
Breathing problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Dyspnea(shortness of breath)	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

### Sleep

Daytime Sleepiness	Y	N
Morning headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N
How often?	_____	
Has anyone told you that you snore?	Y	N

### Social History

Do you smoke? N Y \_\_\_ packs a day

Do you use smokeless tobacco? Y N

Do you consume alcoholic beverages? \_\_\_\_\_ Drinks per day/week/month

Do you use recreational drugs? Y N

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**MEDICAL HISTORY and CONSENT**

List any medications you are taking:

List any surgeries or hospitalizations you have had:

Medication	Dosage/Freq.	Prescriber	Reason	Date(year)	Surgery	Surgeon	Reason
1. _____				_____			
2. _____				_____			
3. _____				_____			
4. _____				_____			
5. _____				_____			
6. _____				_____			

List and detail any medical condition or history not listed above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary Physician’s Name: \_\_\_\_\_ Physician’s phone #: \_\_\_\_\_

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason
_____	_____	_____
_____	_____	_____

**GENERAL CONSENT TO DIAGNOSE AND TREAT:** The undersigned hereby authorizes Dr. Tontra Lowe or her representative to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient’s dental condition and needs. I authorize Dr. Tontra Lowe to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Dr. Tontra Lowe choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Dr. Tontra Lowe. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient’s health. It is my responsibility to inform the dental office of any change in medical health or status.

**FINANCIAL CONSENT:** I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1 1/2% finance charge (18% annually) that will be applied to any balance over 60 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Dr. Tontra Lowe and her staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to her, and to handle any necessary claim appeal(s) on my behalf.

**Consent (adult):**

Name of Patient \_\_\_\_\_ Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

**Consent (for a minor child):**

Name of Parent/Guardian \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Notice of Privacy Practices (below)**

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information (“PHI”) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices’ policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable), my other medical providers, and \_\_\_\_\_ (Name of Spouse, Parent, Grandparent, Guardian, or Other Designee).

\_\_\_\_\_  
Signature of Patient Date \_\_\_\_\_

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## Financial Agreement

We pride ourselves on offering the best customer service available, and will gladly submit your claims to any insurance company you prefer. Remaining payment of the patient's portion is due no later than the day the dental service is rendered except for extensive treatment, Six-Month Smiles treatment and Clear Aligners.

All treatment plan costs presented are ESTIMATES only; I will be responsible for the applicable financial differences. I understand that my specific policy is an agreement between the insurance company and me, and I am responsible for any financial differences. Should for any reason the insurance benefits result in less than the coverage anticipated, I understand that I am the responsible party for the total obligation.

Every effort is made to bill my insurance directly for reimbursement; however, if they do not pay within 60 days, I am still responsible for all remaining treatment fees. If I fail to notify Awesome Smiles of any insurance change, I will be fully responsible for any amount not paid by my insurance.

I agree to pay finance charges of 1.5% per month (18% APR) on any balance 60 days past due. If sent to collections, I agree to pay all related fees and court costs. Any check not cleared through the bank and returned to our office because of an insufficient balance will incur to the patient a \$35.00 service fee.

There are many times that our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give the office advance notice of their need to cancel a scheduled appointment, this time can then in turn be allocated to these patients in urgent need of treatment. In this way the office can best serve the needs of ALL patients. With this in mind, a fee of **\$75/person/30 min is charged for patients who cancel without a 48-hour notice, which does not include after office hours, weekends, text, or email**. We cannot access text messages and email is only available during office hours. For sedation patients, a 72-hr notice is required.

To reserve time with the doctor, a portion of the patient's co-pay is due at the time of scheduling. Any remaining payment is due on the day the dental service is rendered except for extensive treatment, Six-Month Smiles treatment and Clear Aligners. Payment Options: Cash, Check, Visa, Mastercard, Discover, CareCredit (not all co-pays qualify), and Lending Club (allows payments over time with little to no interest)

Any medical payments sent directly to you mistakenly must be brought to the office within three (3) business days of receipt. Please make sure to bring the entire explanation of benefits with the payment to balance your account. Refunds are issued after all claims have been filed and all payments posted to your account. Failure to do so will result in collections initiated on your behalf.

We will bill all balances that remain on your account, after all insurance and co-pay amounts are applied, to your primary credit card on-file with the office. Please inform office personnel if you prefer to have a specific card used for billing. You will receive statement notification prior to any charges being applied. Emergency appointments after hours and on weekends incur an automatic \$150 cash payment in addition to any treatment completed during the appointment. Failure to come to the scheduled emergency appointment will still incur the charge if the doctor is not notified and arrives to treat you, but you elect not to come.

\_\_\_\_\_  
Patient, Parent, or Guardian Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date



Dear Patient:

Welcome to Awesome Smiles! We are so happy that you have chosen our office for your dental needs. You have certainly selected the right office, doctor, and team. We believe everyone should smile with confidence, not embarrassment, and we strive to make your visits with us the most comfortable possible.

In order for us to provide the ultimate patient experience each time you are here, we have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception- dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payment.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract. However, it should be understood, that the dental insurance contract is between the insurance company and the patient, who bears the ultimate financial responsibility.

Once you arrive at the office for your first appointment, we will happily provide you with a complimentary insurance benefits analysis that is extremely helpful to many of our patients. Please take the time to review the information we are providing which is what we use to determine any coverage and fees. It will also benefit you greatly to study your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

Sincerely,

Dr. Lowe and Staff

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Printed Name

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Signature

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Date