2020 ANNUAL REQUIRED UPDATE

Awesome Smiles Dental Center

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) 571-261-2600 (FAX)

PATIENT INFORMATION

Name _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: _____
First MI Last

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: _____

INSURANCE INFORMATION *Any change to your Medical or Dental Insurance*?

Yes ☐ No ☐ ***Please skip below to the Medical History and Consent section.***

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

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

MEDICAL HISTORY and CONSENT

List any medications you are taking:

Medication	Dosage/Freq.	Prescriber	Reason
1.			
2.			
3.			
4.			
5.			
6.			

List any surgeries or hospitalizations you have had:

Date(year)	Surgery	Surgeon	Reason

List and detail any medical condition or history not listed above such as CANCER or CURRENT PREGNANCY:

_____

_____

_____

_____

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 or other designated representative 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 medical and/or dental 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 _____ _____ **Date** _____

Signature of Patient

Consent (for a minor child):

Name of Parent/Guardian _____ _____ **Date** _____

Signature of Parent/Guardian

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 medical and dental insurance company (if applicable), my other medical providers, and _____(Name of Spouse, Parent, Grandparent, Guardian, or Other Person designated to act on your behalf).

_____ **Date** _____

Signature of Patient or Parent/Guardian

Awesome Smiles Dental Center

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 $40.00 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 is 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.** Staff cannot access text messages or email outside of 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 may be *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 or dental 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 or notice of income sent to the Internal Revenue Service (IRS).

We will bill all balances that remain on your account, after all insurance and co-pay amounts are applied, to the last credit card used in the office. Please inform office personnel if you prefer to have a specific card used for billing. We will send a statement via mail and/or secure email prior to any charges being applied. Emergency appointments after-hours and on closed weekends incur an automatic $150 cash payment, due prior to being seen, in addition to fees for 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

Updated 12/29/19TL