BIRKITT DENTAL

Welcome to Our Practice!

Please take a few minutes to answer the following questions so that we may better assist you with your oral health needs:

Patient Information

Name: _____

SS#: _____ Birthdate: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: ___ Zip: _____ E-mail: _____

Sex: ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Long-term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer: _____ Business Phone: _____

Who should we thank for referring you? _____

Emergency Contact: _____ Phone: _____

Responsible Party Information

Name (if different from above): _____

Relationship to Patient: _____ Birthdate: _____ SS#: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: ___ Zip: _____ E-mail: _____

Employer: _____ Yrs. Employed: _____

Occupation: _____ Business Phone: _____

Business Address: _____

City: _____ State: ___ Zip: _____ E-mail: _____

Insurance Information

Insured Name: _____

Relationship to Patient: _____ Birthdate: _____ SS#: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: ___ Zip: _____ E-mail: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D.#: _____ Group#: _____

Assignment and Release

I hereby authorize payment directly to Cary T. Birkitt, D.D.S., Ltd. for all insurance benefits otherwise payabe to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize Cary T. Birkitt, D.D.S. and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____

18 Loudoun Street, SE • Leesburg, Virginia 20175 • P: 703-777-4440 F: 703-777-6254 W: birkittdental.com

PLEASE COMPLETE REVERSE SIDE

Health History Information

Dental History

Former Dentist: _____ Date of Last X-Rays: _____

City, State: _____ How Often Do You Floss? _____

Date of Last Dental Visit: _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

Medical History

Physician's Name: _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	○	○
2. Have you ever had any serious illnesses or operations?	○	○
3. Are you currently taking any medication?	○	○
Please describe _____		
4. Do you smoke?	○	○
5. Do you use alcohol?	○	○
6. Do you use cocaine?	○	○
7. Do use other drugs	○	○
Please describe _____		
8. Do you wear contact lenses?	○	○

9. Have you had any allergic reaction to the following:	Yes	No
Local Anesthetics (e.g., novocaine)?	○	○
Penicillin or other Antibiotics?	○	○
Sulfa Drugs?	○	○
Barbiturates (sleeping pills)?	○	○
Sedatives?	○	○
Iodine?	○	○
Aspirin?	○	○
Other?	○	○
10. (Women Only) Are You:		
Pregnant?	○	○
Nursing?	○	○
Taking birth control pills?	○	○

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough—persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

BIRKITT DENTAL

Financial Policy

We appreciate your selection of our office to serve your oral health needs. Our goal is to provide the very best possible dental care for our patients so that each may achieve optimal dental health throughout their lifetime. We hope that you understand that our credit and collection policies are a necessary part of assuring that the financial resources needed to maintain this office for you and the community are preserved. Therefore, we have instituted this Financial Policy. We ask that ALL RESPONSIBLE PARTIES READ AND SIGN this Policy before being seen by our doctors.

Unless prior arrangements are discussed, PAYMENT FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, checks, VISA or Mastercard. We are happy to process your insurance claim for any carrier with which we are able to do so. For us to complete this task, it will be necessary that you provide us with your current dental insurance card and any other necessary information that may be needed to file your claim. We may accept assignment of insurance benefits for some carriers. Any problems that may arise between you and your insurance company dictates that we inform you of the following:

1. YOUR INSURANCE POLICY IS BETWEEN YOU, YOUR EMPLOYER WHEN APPLICABLE AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. OUR RELATIONSHIP IS WITH YOU, THE RESPONSIBLE PARTY.
2. All charges are your responsibility whether your insurance company pays or not. All services may not be covered under your insurance policy. You will be responsible for payment of any non-covered services, unpaid deductibles, and co-payments at the time of service.
3. In the event that your insurance carrier has not made necessary payment within 30 days, you are asked to contact the carrier to facilitate the process and to provide any additional information necessary to process your claim.
4. In the event that your insurance carrier has not made necessary payment within 60 days, you are asked to make payment in full.
5. Accounts outstanding more than 60 days from treatment date will bear interest at 1-1/2% per month or 18% per annum.
6. Accounts on which checks have been returned for insufficient funds will have a charge of $25.00 added to the balance. Additional personal checks will then no longer be accepted for payment.
7. All balances older than 120 days will be reviewed and reported to Equifax Credit Bureau.

We understand that temporary financial problems may affect timely payment of your balance. In many cases, applying for CareCredit or Citi Health Card through our office can be a viable payment alternative.

Again, thank you for choosing our office for your dental needs.

I HAVE READ THE FOREGOING FINANCIAL POLICY AND AGREE TO FOLLOW ITS TERMS AND CONDITIONS.

Signature: _____ Date: _____

Signature: _____ Date: _____

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PLEASE COMPLETE REVERSE SIDE

Cancellation Policy

At Birkitt Dental, we value time greatly, both that of our patients and that of our doctors and staff. When an appointment is missed, not only does that deprive you of your needed treatment, but it also deprives another patient who would have liked to have been seen in that time slot.

We do many things to help our patients remember their appointments including sending reminder postcards, emails, and making reminder phone calls.

We ask that our patients give us at least 24 hours (1 business day) notice of schedule changes. If 24 hours (1 business day) is not given, your account may be charged a $50.00 per hour cancellation fee.

Signature: _____ Date: _____

BIRKITT DENTAL

HIPAA Ominbus Rule

Patient Acknowledgement Form for Receipt of Notice of Privacy Practices Consent/Limited Authorization and Release Form

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

How do you want to be addressed when summoned from the reception area:

☐ First Name Only ☐ Proper Surname ☐ Other _____

Please list any other parties who are actively involved in your health care and who can have access to your health information (this includes step grandparents, grandparents and any care takers who can have access to the patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office to **confirm my appointments, treatment and billing information** via:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Email Confirmation

☐ Home Phone Confirmation ☐ Work Phone Confirmation ☐ Any of the Above

I authorize **information about my health** be conveyed via:

☐ Cell Phone ☐ Text Message to my Cell Phone ☐ Email

☐ Home Phone ☐ Work Phone ☐ Any of the Above

I approve being contacted about **special services, events, fundraising efforts or new health information** on behalf of Birkitt Dental via:

☐ Phone Message ☐ Text Message ☐ Email

☐ Any of the Above ☐ None of the Above (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that Birkitt Dental may recommend products or services to promote your improved health. Our office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a phi document release should I request treatment or radiographs be sent to other attending doctor/facilities in the future.

_____ _____

Please **print** name of Patient Please **sign** Patient/Guardian of Patient

_____ _____

Legal Representative/Guardian Relationship of Legal Representative/Guardian

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

☐ It was emergency treatment

☐ I could not communicate with the patient

☐ The patient refused to sign

☐ The patient was unable to sign because _____

☐ Other (please describe) _____

Signature of Privacy Officer _____

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