Welcome to our office. Please take a moment to enter your information to help us ensure the quality of your care is excellent. We look forward to working with you

Hometown Dental Care

Patient Information

Name :(Last, First, MI)_____ **Preferred Name:** _____

Address:_____ **City:**_____ **State:** _____ **Zip:** _____

Birth Date:_____ **Age:**_____ **Sex:** ◯ M◯ F **SSN:** _____ **Family Status:** Single/ Married/ Divorced/ Widowed

Phone: (____)_____ **Cell Phone: (___)**_____ **Best time to call:** _____

Driver License No:_____ **Email:**_____ **Employer/Occupation:** _____

Employer Address:_____ Whom may we thank for referring you to our practice?_____

In case of emergency, contact:_____ Relationship: _____

Primary Dental Insurance

Name of Subscriber :(Last, First, MI)_____ **Relationship to patient:**_____

Address (if different from Patient's):_____ **City:**_____ **State:** _____ **Zip:** _____

Subscriber's Date of birth:_____ **Subscriber ID:**_____ **Group #:**_____

SSN:_____ **Employer Name:**_____ **Employer Address:**_____

Secondary Dental Insurance

Name of Subscriber :(Last, First, MI)_____ **Relationship to patient:**_____

Address (if different from Patient's):_____ **City:**_____ **State:** _____ **Zip:** _____

Subscriber's Date of birth:_____ **Subscriber ID:**_____ **Group #:**_____

SSN:_____ **Employer Name:**_____ **Employer Address:**_____

Insurance Authorization:

☐ By checking this box,

I authorize my insurance to pay my benefits directly to the dentist for all services rendered.

I authorize this practice to submit insurance claim forms and receive payment directly from the insurance carrier with the notation "signature on file"

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges, whether or not paid by insurance.

Patient/ Parent or Guardian Signature: _____ Date: _____

Dental Information

What is the reason for this appointment?_____

What is your immediate concern?_____

Date of most recent dental exam/ x-rays: _____

Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10 (most) _____

How would you rate the condition of your mouth? ◯Excellent ◯Good ◯Fair ◯ Poor

Check all that apply:

◯ Have you ever whitened your teeth?	◯Problems with your jaw joint	◯ Problems chewing
◯ Clench your teeth during the daytime /nighttime	◯ Cavities within past 3 years	◯ Sensitive to hot, cold, sweets
◯ Gums bleed easily when brushing or Flossing	◯ chronic bad breath or bad taste	◯ Suffer from snoring & sleep apnea
◯Experienced burning sensation in Your mouth	◯ Trouble getting numb	◯had/ have braces, orthodontic treatment

If any of the checked circles need further explanation, please describe:

_____

_____

How often do you brush? _____ How often do you floss? _____

Do you suffer from snoring & sleep apnea?_____ If yes, please fill out "Epworth Sleepiness Scale" form.

Patient Treatment Consent

☐ By checking this box, I authorize the Dentist (s) treating me or my dependents to perform recommended treatment and procedures. I understand that during treatment, unforeseen conditions may arise which may necessitate procedures different from those discussed prior to treatment. I therefore consent to the performance of any additional treatment which the dentist considers necessary and mutually agreed by me.

Patient/ Parent or Guardian Signature: _____ Date: _____

Medical History

To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Indicate which of the following you have had or have at present. Please check all that apply.

- ◯ Any heart problems
- ◯ Heart murmur
- ◯ Mitral valve prolapsed
- ◯ Heart valve defect
- ◯ Rheumatic fever
- ◯ Artificial joint
- ◯ Angina
- ◯ Stroke
- ◯ Heart attack
- ◯ Bypass
- ◯ Pacemaker
- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Any bleeding disorders
- ◯ Anemia
- ◯ Hemophilia
- ◯ Sickle cell trait
- ◯ Blood transfusions
- ◯ Do you smoke?
- ◯ Lung/breathing problems
- ◯ Asthma
- ◯ Emphysema
- ◯ Tuberculosis
- ◯ Sinus trouble
- ◯ Difficulty in healing
- ◯ Diabetes
- ◯ Thyroid Problems
- ◯ Adrenal/ pituitary problems
- ◯ Liver Problems
- ◯ Hepatitis/ Jaundice
- ◯ Kidney Problems
- ◯ Stomach trouble/ ulcers
- ◯ Nervous or mental Disorders
- ◯ Epilepsy or Seizures
- ◯ Alcoholism
- ◯ Drug abuse
- ◯ Cancer/ Tumor
- ◯ Other growths
- ◯ Chemo/ radiation therapy
- ◯ Sexually transmitted diseases
- ◯ Other infectious Disease
- ◯ HIV/ AIDS
- ◯ Are you pregnant?
- ◯ Are you nursing?

Allergic reaction (hives/swelling) to: (check all that apply)

- ◯ Penicillin
- ◯ Erythromycin
- ◯ Sulfa
- ◯ Codeine
- ◯ Nickel or other metals
- ◯ Aspirin
- ◯ Latex
- ◯ Local Anesthetic (Novocain)
- ◯ Other Medications or Substances? Please list: _____

If any condition or alert selected above needs further clarification, please explain below:

_____

Do you need to take antibiotic pre-medication prior to dental appointments? ◯ Yes ◯ No **Name of Antibiotic:** _____

Are you currently under a physician care? _____ For what reason: _____

Physician's name, address and phone number: _____

Are you presently taking any medications, pills, or tonics? (i.e., Blood pressure, birth control, steroids, hormones) ◯ Yes ◯ No

Medication	For	Medication	For

◯ I certify that the above information is complete and accurate to the best of my knowledge. I will inform the dentist of any changes in my heath status or my medications.

Patient/ Parent or guardian signature: _____ Date: _____

Doctor signature: _____ Date: _____

Patient Smile Evaluation Form

Name:_____ Date:_____

To help diagnosis and create a treatment plan based off of your concerns, please take a moment and answer the following questions. Please circle your answer.

Do you dislike the color of your teeth?

YES ___ NO___

Do you have spaces between your teeth that bother you?

YES___ NO___

Do you have chips or uneven edges on your teeth?

YES___ NO___

Do you feel that your teeth are too long or too short?

YES___ NO___

Do you have dark fillings that show when you smile?

YES___ NO___

Do your gums show too much when you smile?

YES___ NO___

Are your teeth crowded or crooked?

YES___ NO___

Do you have existing crowns or dental work you consider “ugly”?

YES___ NO___

Are you self-conscious of your teeth and/or smile?

YES___ NO___

Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile?

YES___ NO___

Do you avoid smiling when you have your picture taken?

YES___ NO___

Would you like to improve your existing smile?

YES___ NO___

Do you wish you had a “new smile”?

YES___ NO___

Please checkmark next to which of the following are concerns you have regarding dental treatment to improve your smile:

Fear of treatment:

Time of treatment concerns:

Financial concerns:

Distance to office:

Not understanding treatment:

Embarrassment:

Other:

Epworth Sleepiness Scale

Name: _____ Date: _____

Your age (yrs) _____ Sex: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0=would **never** doze

1=**slight chance** of dozing

2=**moderate chance** of dozing

3=**high chance** of dozing

Situation	**Chance of Dozing (0-3)**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

HOMETOWN DENTAL CARE

Arezou Daneshvar, DDS

821 S. King Street, Suite E
Leesburg VA 20175

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of *HOMETOWN DENTAL CARE HIPAA Notice of Privacy Practices*.

I understand that *HOMETOWN DENTAL CARE*, *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of *HOMETOWN DENTAL CARE* revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about *HOMETOWN DENTAL CARE HIPAA Notice of Privacy Practices*, I may contact Dr. Arezou Daneshvar.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that *HOMETOWN DENTAL CARE* will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding *HOMETOWN DENTAL CARE* privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Dr. Arezou Daneshvar noted above, for assistance.

_____	_____
Patient Signature	Date
_____	_____
Signature of Personal Representative	Print Name of Personal Representative
	_____
	Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

HOMETOWN DENTAL CARE made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, *HOMETOWN DENTAL CARE* was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practice provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

YES___ NO___

May we leave a message on your answering machine at home or on your cell phone?

YES___ NO___

May we discuss your medical condition with any member of your family?

YES___ NO___

If **YES**, please name the members allowed:

_____

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE) _____ Date: _____

Doctor Signature: _____ Date: _____

Witness: _____ Date: _____