WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #:____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate:____/____/____ Age:_____ SS#: _____

Mailing Address:_____

_____
CITY STATE ZIP

Home Phone #: (_____)_____

Work Phone #: (_____)_____ Ext:_____

Cell Phone #: (_____) _____

E-mail Address:_____

Referred By: _____

Employer: _____How Long?_____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

two INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address:_____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name: _____

Relation:_____Date of Birth:____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address:_____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name: _____

Relation:_____Date of Birth:____/____/____

Insured's Employer: _____

three ACCOUNT INFO

Person ultimately responsible for account

Name:_____

Relation: _____

Billing Address:_____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____)_____

Payment method: ❑ Cash ❑ Check

_____ ____/____

❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance
Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four IN EVENT OF EMERGENCY

Whom should we contact?_____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor?_____

Medical Doctor's Phone #: (_____) _____

PLEASE CONTINUE ON BACK

five

DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How Long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ (____) _____
Name Phone#

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

six

MEDICAL HISTORY

What medications are you taking? ❑ **Nerve pills** ❑ **Pain killers** (including aspirin) ❑ **Muscle relaxers**
❑ **Stimulants** ❑ **Blood Thinners** ❑ **Tranquilizers** ❑ **Insulin** ❑ **Meds for Osteoporosis**
❑ **Other(s), please list:** _____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Thyroid Problems	Y N Cancer/Tumors	Y N Cosmetic Surgery
Y N Heart Surg./Pacemaker	Y N Kidney Problems	Y N Shingles	Y N Xray or Cobalt Treatment
Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Arthritis/ Rheumatism	Y N Difficulty Breathing
Y N Artificial Valves	Y N Stomach Problems/Ulcers	Y N Artificial Bones/Joints	Y N Diabetes/Hypoglycemia
Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	Y N Leukemia
Y N Congenital Heart Defect	Y N Venereal Disease	Y N Fainting/Seizures/Epilepsy	Y N Anemia
Y N Chest Pains	Y N Alcohol/Drug Abuse	Y N Severe/Frequent Headaches	Y N High/Low Blood Pressure
Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck Pain	Y N Bleeding Problems
Y N Nervousness	Y N Jaw Problems TMJ/TMD	Y N Back Problems	Y N Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin

❑ Dental Anesthetics ❑ Foods: _____ ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? _____

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

Initials ____ Date ____/____/____
Comments

Initials ____ Date ____/____/____
Comments

Initials ____ Date ____/____/____
Comments

Michael Polifko, DDS
Mary Catherine Dvorak, DDS
2010-D Opitz Boulevard
Woodbridge, VA 22191
P: (703)494-6690 F: (703)494-9600

Welcome to our Practice!

Thank you for choosing our office for your dental health needs. We would like to acquaint you with our office policies. It is our goal to provide quality dentistry within a caring and friendly environment. We hope that you and your family feel welcome here.

Dental Insurance

Our practice is currently in network (participating) with United Concordia and MetLife. However, we do accept all PPO policies. Due to our out of network (non-participating) status, you may be required to pay for your visit in full and be reimbursed by your insurance. As a courtesy we will file your insurance claims for you to expedite your reimbursement. There may be times when we are unable to file on your behalf; in these cases we will provide you the appropriate forms to file. We do not accept HMO, DMO, Medicaid or Medicare insurance. Any non-covered service or portion of any services not paid by your insurance is due at time of service. Any insurance claims not paid by your insurance company within 45 days will become your responsibility in full. All dental policies differ in coverage; please refer to your individual policy for details.

X-Ray Transfer

Please request any current x-rays be sent to our office. Current x-rays are bitewings less than 1 year and full mouth series (FMX) and/or panorex less than 5 years old. These x-rays are needed to provide you with the best dental care possible. If we do not have recent x-rays it will be necessary for us to take the needed x-rays. Due to insurance guidelines, new x-rays taken before their due date will not be covered.

Cancellations and Broken Appointments

We realize that emergencies occur and it is not always possible to give us 48 hour notice for an appointment that you are unable to keep. We do take this into consideration, however, we do reserve the right to charge a minimum of $50.00 for appointments broken without 48 hour notice. This policy allows us to schedule another patient in need of dental care.

OSHA/HIPPA

You will be asked to review and update your medical history on an annual basis to notify us of any changes. We have a legal obligation to keep your information private. Such updates enable us to provide you with safe dental care. If you refuse to update the forms, we reserve the right to refuse treatment.

Section 32 1-23(A) and (B) Code of VA (1950), as amended) provides that, in the event of significant exposure (e.g. needle stick) consent for testing for Human Immunodeficiency Virus (HIV) and Hepatitis will be given by the patient and/or the healthcare worker. Test results are confidential and can only be released in accordance with applicable laws and the policy of the testing facility.

Authorization

I authorize the release of information and payment of my dental benefits to the dentist. I have read and understand the above policies regarding insurance and financial agreements. I also understand that in the event my account becomes delinquent, I will be responsible for any collections, attorney's fees and court costs, including any other charges incurred to collect payment for my account.

Signature: _____ Date: _____

Michael Polifko, DDS
Mary Catherine Dvorak, DDS
2010-D Opitz Boulevard
Woodbridge, Virginia 22191
(703) 494-6690

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct, or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (*e.g.*, my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *NOTICE of PRIVACY PRACTICES* which contains a more complete description of the uses and disclosures of my protected health information and my rights under *HIPAA*. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use of disclosure that occurred prior to the date that I revoke this consent is not affected.

Patient Name: _____ Relationship to Patient: _____
(print)

Signature: _____ Date: _____

Michael Polifko, DDS
Mary Catherine Dvorak, DDS
2010-D Opitz Boulevard
Woodbridge, Virginia 22191
(703) 494-6690

X-ray Policy Information

In order to provide our patients with the best care possible, certain x-rays are required. Such x-rays do carry frequency limitations with insurance companies. If you have a history of the following, we do ask that you request copies from your previous Dentist.

- Bitewing x-rays within the last 12 month
- Full mouth or Panoramic x-rays within the last 5 years

Prior to your first visit with us we will verify your x-ray history thru the insurance information you provide to us, provided there is adequate time before you are seen.

In the event you are not eligible for the required x-rays and are not able to obtain copies prior to your initial visit, it will be necessary for us to take new films at your cost or reschedule your appointment until such time that x-rays become obtainable.

If you have any questions for any reason, please call our office and a member of our staff will be happy to help you.

We look forward to caring for all your dental needs.

Respectfully yours,

Dr. Michael Polifko, DDS & Dr. Mary Catherine Dvorak, DDS

Patient Name: _____ Relationship to Patient: _____
(Print)

Signature: _____ Date: _____