



Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____



Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient



Phone Numbers

Home (____) _____ Work (____) _____ Ext _____ Cell Phone (____) _____

Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____



Dental History

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

Dental Registration and History



Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | | | |
|---|--|-----------------------|--|------------------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with
extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head
or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No



Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (____) _____



Allergies

Aspirin

Local Anesthetic

Barbiturates (Sleeping pills)

Penicillin

Codeine

Sulfa

Iodine

Other _____

Latex



Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

We are delighted that you have chosen our practice for your dental care. Consistent dental care is essential to your general health and well being. Our goal is to provide “state of the art” comprehensive oral care, utilizing the most up to date dental equipment available in conjunction with the best dental materials available. Excellence is our passion. Toward this goal, we are providing you with information on policies and procedures for our practice. After reading this, please sign and date at the bottom. Please feel free to ask any questions you may have.

Hours of Operation:

Our hours of operation are Monday through Thursday 9:00 a.m. to 5:00 p.m. The office staff is available for phone calls from 8:00 a.m. to 3:00 p.m. on Friday. In the event of a dental emergency, there is a number provided on our phone system that will direct you to the doctor. In the event of inclement weather, please call the office for information regarding your appointment for that day.

Health History:

We are a dental/medical practice and as such we will periodically ask you for updates of your personal and medical history. This information is important to your treatment, and your cooperation in completing these updates is appreciated.

Importance of Recall Appointments:

We make every effort to schedule your next hygiene recall appointment before you leave. This allows us to keep a close eye on your previous dental work and the dental work that we’ve completed. We take pride in our dentistry and your help in keeping your routine cleaning and exams will insure that your teeth and your dental work will serve you for the longest time.

Confirmation Procedure:

As a courtesy, we will call you 24 to 48 hours prior to any appointment to remind you of the date and time. If you need to reschedule your appointment, you will need to call our office during regular business hours. Our regular business hours are Monday through Thursday 8:00 a.m. to 5:00 p.m. We need a **48** hour notice if you cannot keep an appointment. A fee of **\$75.00** per half-hour will be charged for patients who have a broken appointment with the dentist, and **\$75.00** per hour for hygiene appointments.

Insurance Policy Statement:

If you have dental insurance, we ask that you provide us with a card at the time of your first visit. As a courtesy, we will inquire with your insurance company for basic information, limited to eligibility and the insurance percentages of coverage that we are able to obtain. The patient/parent/guardian or covered family member must follow up all detailed inquiries. We will file claims to your dental insurer at each visit. Pre-determinations are submitted upon request, however is still not a guarantee of benefits. It is important that you recognize that we are providers only for the following insurance companies: **Cigna, Delta Dental, Guardian, Metlife, United Concordia, and United Healthcare.** You will be responsible for any balance not covered by insurance. **Payment is due at the time of services.** Please contact your insurance company if you are not being covered. **THIRTY DAYS AFTER THE DATE OF SERVICE, PAYMENT IS DUE IN FULL, REGARDLESS OF THE STATUS OF INSURANCE.** Please notify us of any changes in your insurance.

If you don't have dental insurance, payment is expected at the time of service.

Methods of Payment:

All member of a family will be carried on the same account unless you request other wise. We accept cash, check, and all credit cards. There is also medical credit that is offered to you called Care Credit. If your credit is approved, your dental treatment can be financed through Care Credit for up to 24 months at no interest to you.

Financial Policy:

If an account should be turned over to a collection agency and/or attorney for collections, I agree to pay the cost of the collection agency, court cost, and attorney fees.

Our Guarantee:

All treatment that is diagnosed is to the best of Dr. Akeel's dental knowledge and abilities. A guarantee on materials used for treatment applies solely to patients that attend regularly scheduled recare appointments determined by the dental hygienist or doctor.

Signature of Patient/ Parent/Guardian

Date

Dr. Ed Akeel, D.D.S
2003 Woodbrook Court
Charlottesville, Virginia 22901

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (07-19-07), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals' evaluation practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patients Rights section of this Notice. We may disclose your health information to a family member, friend or other person to extent necessary to help with your health care or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose

health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the persons involvement in your healthcare. We will also use your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose you health information to appropriate authorities if we reasonably believe that are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose you heath information to the extent necessary to avert a serious threat to your heath or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody pf protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited expectation. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your heath information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies. You may also request access by sending us a letter to the address at the end of this Notice. If you prefer, we will prepare a summary or an explanation of your health information. Contact us using the information listed at the end of this Notice for a full explanation.)

Discloser Accounting: You have the right to receive a list of instances in which we or our business associated disclosed your health information for purposes, other than treatment, payment, healthcare, operations and certain other activities, for the last 6 years, but not before July 9, 2007. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional request.

Restriction: You have the right to request that we place additional restrictions on our use or disclose of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or location. (You must make your request in writing.) Your request must specify the alternative means or locations, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-rmail), you are entitled to receive this in written form.

Ed A. Akeel, BDS, DDS, FAGD
P.O. Box 8065
Charlottesville, VA 22906
434-975-6181 (office)
434-220-3157 (fax)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's
Notice of Privacy Practices.

Please print name

Signature

Date

For office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify)

