White Tree Dental

44031 Pipeline Plaza Suite #215 Ashburn VA20147

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____
(Last, First M.I.)

Social Security #: _____-_____-_____ Gender: F / M Married: YES / NO Date of Birth: _____

Phone #: (Home) _____ (Work) _____ (Mobile) _____

Address: _____
(Street Apt #)

_____
(City State Zip Code)

Patient Employer/School: _____ Occupation: _____

How did you hear about our practice? _____

In case of emergency, who should be notified? _____ Phone #: _____

Email address _____

If the patient is a minor, please provide the legal guardian's information…

Legal Guardian Name: _____ Relation to Patient: _____
(Last, First M.I.)

Social Security #: _____-_____-_____ Gender: F / M Married: YES / NO Date of Birth: _____

Phone #: (Home) _____ (Work) _____ (Mobile) _____

Address: _____
(Street Apt # City State Zip Code)

Patient Employer/School: _____ Occupation: _____

INSURANCE INFORMATION

Primary Dental Insurance: _____Subscriber's Name: _____

Subscriber's DOB: _____ Subscriber's SS#:_____Relation to Patient: _____

Group ID: _____ Member ID: _____

Secondary Dental Insurance: _____Subscriber's Name: _____

Subscriber's DOB: _____ Subscriber's SS#:_____Relation to Patient: _____

Group ID: _____ Member ID: _____

I certify that I am/my dependents are covered by insurance with _____ and assign directly to Dr. Chris K. Park 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.

Patient Signature: _____ Date: _____

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DENTAL HISTORY & HEALTH INFORMATION

Reason for Today's Visit: _____

Date of Last Dental Care: _____ Date of Last Dental X Rays: _____

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

(FEMALE PATIENTS ONLY) Are you currently PREGNANT? ☐ Yes ☐ No If Yes, how many months? _____

List ALL medications you are currently taking (ex. Aspirin): _____

_____

List ALL current and previous medical conditions (ex. high blood pressure, diabetes): _____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? ☐ Yes ☐ No

If YES, please explain: _____

DO YOU HAVE ANY HEART/MEDICAL CONDITIONS THAT REQUIRE YOU TO BE PREMEDICATED? ☐ Yes ☐ No

If YES, please explain: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" ☐ Yes ☐ No

These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfendluramine).

ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? ☐ Yes ☐ No

If YES, please provide the Name and Phone Number of Physician: _____

Name Phone Number

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

Have you been admitted to a hospital or needed emergency care during the past 2 years? ☐ Yes ☐ No

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If you answered YES to any of the three questions above, please explain:

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

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 health care 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 any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

White Tree Dental

OFFICE FINANCIAL POLICY AND INSURANCE PAYMENT AUTHORIZATIONS

Thank you for choosing our office to serve your dental needs. We strive to provide the highest quality treatment at a reasonable cost to you. The following is a statement of our financial policy and insurance payment authorizations. Please read this document very carefully and sign below. If you have any questions or concerns about this policy and authorizations, a member of our qualified staff will be happy to discuss your concerns with you.
The following payment options are available:

① Cash
② Visa, MasterCard, and Discover

We cooperate fully with our patients who are covered by insurance plans. We expect insured patients to read their policies carefully. It is very important that you are familiar with its benefits and limitations. We will accept assignment of benefits provided the necessary documentation has been provided. We do require that you pay your deductible and/or estimated co-pay at the time of service. If your insurance company has not paid your account in full within 45 days of treatment or denies your claim for ANY reason, you will be held responsible for the total balance.

- All emergency treatment visits that are initial visits are to be paid in full on the day of service. However, we will gladly assist you in completing your insurance claim forms so you may get reimbursement from your dental insurance company.
- All prosthetic services must be paid in full on or before completion.
- We reserve the right to charge any account balance due over 30 days, a 1.5% monthly charge or a $5 repeat billing charge, whichever is greater.
- You are responsible for any and all collection cost and/or fees associated with collecting the balance of your account.
- We consider the parent or guardian who brings the child to our office for treatment the responsible party for payment of the child's account. If someone else is legally responsible for the child's account, it remains the responsibility of the parent or guardian bringing the child in for treatment to seek reimbursement for payment made to our office. We will be happy to assist you by providing you with a copy of the charges and payments made at each visit.
- The office reserves the right to charge $30 per half hour for a broken appointment. To avoid this charge, 48 hours prior notice must be given.
- A $25 fee will be added to your account for any checks returned to us by the bank.
- A $15 fee will be assessed for the duplication of dental records/x-rays.

Regarding Dental Insurance Claims, Payment, and Authorizations:

1. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.
2. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
3. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to White Tree Dental.

I have read and agree to the terms in this OFFICE FINANCIAL POLICY AND INSURANCE PAYMENT AUTHORIZATIONS.

Date

Printed Name of Patient

Signature of Patient / Parent / Guardian