ALL SMILES
HARRISONBURG

Patient Information (please print):

Patient Name: _____ **Preferred Name:** _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Social Security #:** _____

Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **Race:** _____

Home Phone: _____ **Cell Phone:** _____ **Email Address:** _____

Residence Address: _____

City, State, Zip: _____

Employer: _____ **Occupation:** _____

Employer Address: _____ **Employer Phone:** _____

Are you a student? ☐ Yes ☐ No **School:** ☐ Full Time ☐ Part Time

Referred by: _____ **Phone Number:** _____

Family Dentist: _____ **Phone Number:** _____

Family Physician: _____ **Phone Number:** _____

If Patient is a minor:

Mother's Name: _____ **Date of Birth:** _____

Father's Name: _____ **Date of Birth:** _____

Emergency Contact: _____ **Phone Number:** _____

Relationship To Patient: _____

Dental Insurance Information:

Policy Holder's Name: _____

Policy Holder's DOB: _____

Policy Holder's Employer: _____

Policy Holder's Address: _____

_____

Relationship to Patient:

☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Company: _____

Member ID: _____

Group Number: _____

Insurance Co. Address: _____

_____

Phone Number: _____

Medical Insurance Information:

Policy Holder's Name: _____

Policy Holder's DOB: _____

Policy Holder's Employer: _____

Policy Holder's Address: _____

_____

Relationship to Patient:

☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Company: _____

Member ID: _____

Group Number: _____

Insurance Co. Address: _____

_____

Phone Number: _____

ALL SMILES
HARRISONBURG

ACKNOWLEDGEMENT AND CONSENT FOR EVALUATION

I consent to treatment as necessary or desirable for the care of the patient named on form, including, but not restricted to drugs, medications or lab tests, which may be used by the dentist or his qualified designate. Photographs both intraoral/extraoral along with impressions may also be taken for diagnostic use. Dental x-rays both intraoral/extraoral may be taken at the initial exam, follow-ups, and as and when deemed necessary. All dental x-rays have minimum radiation exposure. All safety guidelines are followed during exposure. I understand that my dentist will explain the general nature, purpose, risks and alternatives associated with such procedures to me. I understand that I will have an opportunity to ask for more information and to ask questions, and I will do so.

Under Virginia law, I understand that if a health care provider or employee is directly exposed to my body fluids in a manner which may transmit human immunodeficiency virus (HIV) or Hepatitis B or C viruses, I will be deemed to have consented to testing for HIV or Hepatitis B or C viruses and to the release or disclosure of the tests results to that health care provider or employee. I understand that if I am exposed to a healthcare worker's body fluids they will be deemed to have consented to testing for HIV or Hepatitis B or C viruses and to the release or disclosure of the test results to me. I understand that if I do not fully understand any part of this form, I may ask the provider to explain it to me before I sign it.

I authorize Kenneth M. Klamut, DDS or Noeen Arshad, DDS to release information and records of or associated with patient care as required to Payers and others (e.g. regulatory agents, collection agents, courts) for the purposes of determining benefits and secure payment or collection of the charges or to meet requests relative to quality review, utilization review, legal review or medical necessity. I authorize employees, agents or designees for Kenneth M. Klamut, DDS, PC (Kenneth M. Klamut, DDS or Noeen Arshad, DDS) to release information for continuation of care to other health care providers as necessary to provide care in the judgment of providers as otherwise authorized by law. I understand that such medical records may include information regarding HIV/AIDS testing, substance abuse and/or mental health issues. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original. This authorization shall remain valid for a period of one (1) year or until such time as I revoke it in writing.

Signature: _____ **Date:** _____
Patient or Surrogate if patient is incompetent or a minor

_____ _____
Surrogate's Name if signed by Surrogate (print) *Relationship to Patient if signed by a Surrogate*

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I_____, herby acknowledge that I have been given an opportunity to review the practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice. I understand that a printed copy of this Notice is available upon request.

Signature: _____ _____
Patient *Date*

_____ _____
or Legal Representative *Relationship to Patient* *Date*

MEDICAL HISTORY: Please complete the following questions

1. Are you in good health? YES NO
2. Has there been ANY changes in your general health in the past year? YES NO
3. Date of your last physical: _____
4. Have you had any adverse effects from dental treatment? YES NO
5. Please CHECK if you have or have you ever had:
   - ☐ Rheumatic Fever or Rheumatic Heart Disease
   - ☐ Congenital Heart Disease
   - ☐ Cardiovascular Disease:
     - ☐ Heart trouble/heart attack/heart murmur
     - ☐ Coronary artery disease
     - ☐ Angina
     - ☐ High Blood Pressure
     - ☐ Stroke
     - ☐ Palpitations
     - ☐ Heart Surgery
     - ☐ Pacemaker
   - ☐ Lung Disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)
   - ☐ Seizures, convulsions, epilepsy, fainting, dizziness
   - ☐ Psychiatric treatment, depression, anxiety disorder or breakdown
   - ☐ Bleeding disorder, anemia, bleeding tendency, blood transfusion
6. Do you have shortness of breath when walking up two flights of stairs? YES NO
7. Do you bruise easily? YES NO
8. Please CHECK if you have or have ever had:
   - ☐ Liver Disease (jaundice, hepatitis)
   - ☐ Kidney Disease
   - ☐ Diabetes
   - ☐ Thyroid Disease
   - ☐ Arthritis
   - ☐ Stomach ulcers or colitis
   - ☐ Glaucoma
   - ☐ Frequent or recurring mouth sores
   - ☐ Implants placed anywhere in your body (heart valve, hip, knee)
   - ☐ Radiation (x-ray) treatment cancer
   - ☐ Clicking or popping of jaw joint, pain near ear, difficulty-opening mouth, grind or clench teeth
   - ☐ Sinus or nasal problems
   - ☐ Any diseases, drugs or transplant operation that has depressed your immune system
   - ☐ Recurrent infections of any kind
9. Please CHECK if you are using or taking any of the following:
   - ☐ Thyroid Medications
   - ☐ Antibiotics or sulfa drugs
   - ☐ Anticoagulants (blood thinners)
   - ☐ High Blood pressure medicine
   - ☐ Steroids (Cortisone, etc)?
   - ☐ Tranquilizers (Valium, etc)?
   - ☐ Insulin, Diabetes, or similar drug
   - ☐ Digitalis, Inderal, Nitroglycerin, Calcium Channel Blockers, Procardia or, other heart medicine
   - ☐ Aspirin or Ibuprofen (Motrin, Naproxen, etc.)?
   - ☐ Marijuana or other "street" drugs
   - ☐ Antihistamines or decongestants (Seldane)?
   - ☐ Are you taking any or have you taken Phen Fen
   - ☐ Are you now or have you ever taken any bisphosphonate medicine (Fosomax, Actonel or Boniva)
10. Please CHECK if you are allergic or have had a bad reaction to:
    - ☐ Local anesthetic (Novocain, etc)?
    - ☐ Penicillin, amoxicillin, cephalosporins or other antibiotics
    - ☐ Barbiturates, sedatives, etc
    - ☐ Aspirin or Ibuprofen
    - ☐ Codeine or other painkillers
    - ☐ Latex or rubber products
    - ☐ Other allergies or reactions?

    Please list any allergies: _____

    _____

CONTINUED ON NEXT PAGE

Patient Name: _____

11. Do you Smoke or chew tobacco? YES NO
12. Do you use alcohol? YES NO
13. Do you have any other disease conditions or problem not listed above that you think the doctor should know about? YES NO
14. Do you wish to talk with the doctor privately about anything? YES NO

15. Please list any medications you are currently taking:

_____

_____

_____

_____

16. Please list any current or previous medical conditions:

_____

_____

_____

17. Please list any previous hospitalizations:

_____

_____

_____

18. What is your preferred pharmacy (please list name and address): _____

_____

FOR WOMEN ONLY:
If you are using oral contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or any other medication is completed. Please consult with your physician for further guidance.
If you are pregnant, possibly pregnant or trying to become pregnant, surgery, anesthetics or any other medication may significantly harm your developing baby, especially during the first trimester.

1. IS THERE ANY CHANCE YOU ARE PREGNANT? YES NO
2. DO YOU WISH TO HAVE A PREGNANCY TEST? YES NO
3. ARE YOU TAKING ANY FORM OF BIRTH CONTROL? YES NO -- IF YES, WHAT: _____
4. DATE OF YOUR LAST MENSTRUAL CYCLE: _____

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY. THIS IS DONE TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

_____ _____
Signature of person completing health history **Date**

Patient Name: _____

ALL SMILES
HARRISONBURG

Financial Policy

Our office policy is that fees are due at the time of service.

I hereby request and authorize Kenneth M. Klamut, DDS or Noeen Arshad, DDS to perform professional services. I understand and agree that I will be given an estimate for any service upon request I also understand that fees are to be paid AT THE TIME OF SERVICE unless arrangements are made in advance. I understand that insurance coverage is an arrangement between the insurance carrier and the patient. All Smiles Harrisonburg will bill for the insurance carriers, which, the doctor participates, but I am ultimately responsible for payment.

Methods of Payment Accepted

Please check one or more payment option

☐ **CASH** - Total payment or co-pay payment by cash at the time service is rendered.

☐ **CHECK** - Total payment or co-pay payment by check at the time the service is rendered.

☐ **CREDIT CARD** - Total amount or co-pay fees charged to a major credit card at the time service is rendered.

☐ **INSURANCE** - This office will be happy to cooperate with individuals who are covered by insurance. We ask that you read your insurance policy to be sure that you fully understand and are aware of the any limitations of benefits provided. The fees we charge for services rendered to those who are insured are our usual and customary fees, which are charged to all patients for similar services. It is important you understand insurance coverage changes according to each individual plan. Therefore, the payment structure will be different for each plan. One plan may pay a percentage of the fee, such as 50% to 80%, whereas, another will have you pay a deductible of $50-$100 and then pay a percentage of your remaining bill. If insurance doesn't reimburse fully within 30 days you are immediately responsible for payment in full.

Please understand our office does not have authority over your selection of the insurance plan you choose. Please realize the reimbursement to our office and you will vary from each insurance plan; this includes when the carrier will pay for the services rendered. Therefore, we ask you to look at your insurance realistically as a device which helps you pay for surgical care. Please understand we will assist you with your insurance claims, but the obligations for the payment ultimately will be the patient's responsibility. All fees will be due on the day of service even if you have insurance unless arrangements are made in advance with our office.

I authorize All Smiles Harrisonburg to release information and records of or associated with patient care as required by my insurance carrier or third party (including my employer or employer's worker's compensation carrier, regulatory agents, collection agents, courts) for the purposes of determining benefits and secure payment I assign Kenneth M. Klamut, DDS PC (including Kenneth M. Klamut, DDS or Noeen Arshad, DDS) all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for payments of any amount not covered under my insurance plan. I acknowledge that billing for services rendered by All Smiles Harrisonburg to my insurance carrier is done as a courtesy to me and not an obligation of the office. I agree that I will not delay payment and I will pay the balance if a claim is pending more than 30 days from date of service. **(Continued on next page)**

Patient's Name: _____

Financial Policy Continued

Insurance payment doesn't always coincide with our best estimate of amount owed. We do our best to coordinate your benefits with amount owed but all quoted estimates are not guarantees of your particular insurance reimbursement and your benefits may be different. It is your responsibility to verify all insurance reimbursement for any procedure treatment planned if you have concerns about your coverage. Many insurance companies do not pay the difference between white fillings (composites) and silver fillings (amalgams). You are responsible for any difference in cost since composites are more expensive to place. Please contact your insurance company if you have questions regarding their payment policies.

A LATE PAYMENT FINANCE CHARGE is imposed if the balance is not paid within 30 days from the date of service. FINANCE CHARGE is compounded at 1.5% per month (annual rate of 18%). A $10.00 rebilling fee is automatically added if the account if over 30 days past due. A $50.00 returned check fee will be applied to your account if insufficient funds keep your check from clearing.

All broken appointments (no call no show) are $50.00. All surgical and treatment appointments require a one week notice for any cancellations, postponing, or rescheduling of appointments, otherwise they have a fee of $200 per hour. For all non-surgical/non-treatment appointments, we require 48-hours notice for any cancellations, if we do not have a 48-hour notice this will result in a $35.00 cancellation fee unless it qualifies as a broken appointment.

I understand that if my account is referred to a collection agency, I agree to pay all costs of collections, including but not limited to, 35%, whether or not suit is filed. I understand that if my account is referred to an attorney, I agree to pay all costs but not less than $200, including but not limited to 33%, whether or not suite is filed. I hereby waive the benefits of my homestead exception as to this debt. If your account is turned over to a collections agency we will automatically bill your account an administrative fee of $50.

Patient's Name: _____

Person Financially Responsible For Account (Guarantor): _____

Guarantor's Address: _____

_____

Guarantor's Phone Number: _____

My signature affirms that I have read and understand the Financial Policy and I have had the opportunity to have all questions answered to your satisfaction. You also agree to be responsible for all account balances.

Signature: _____ **Date:** _____

ALL SMILES
HARRISONBURG

Permission to Discuss Medical Information

I _____ **Date of birth:** _____ give *All Smiles Harrisonburg* permission to discuss my dental treatment and care with the following persons listed below while I am under the care of *All Smiles Harrisonburg*. This Authorization to remain in effect until revoked in writing by the patient or updated with a new form.

Name: _____

Relationship to Patient: _____

Contact Number: _____

Information to be shared:

___ Diagnosis and treatment information

___ Financial Information

Name: _____

Relationship to Patient: _____

Contact Number: _____

Information to be shared:

___ Diagnosis and treatment information

___ Financial Information

Name: _____

Relationship to Patient: _____

Contact Number: _____

Information to be shared:

___ Diagnosis and treatment information

___ Financial Information

_____ _____

Signature of Patient or Legal Guardian ***Date***

_____

Printed Name of Parent or Legal Guardian

_____

If Legal Guardian, please state relationship to patient