

PATIENT NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_
HOME ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_
HOME PHONE \_\_\_\_\_
BUSINESS NAME \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_
SOC. SEC. NO. \_\_\_\_\_

PATIENT MEDICAL HISTORY

PHYSICIAN \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_ DATE OF LAST EXAM \_\_\_\_\_

- 1. ARE YOU UNDER MEDICAL TREATMENT NOW? YES NO
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? YES NO
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? YES NO
4. DO YOU USE TOBACCO? YES NO
5. DO YOU USE ALCOHOL, YES NO
6. ARE YOU WEARING CONTACT LENSES? YES NO
7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.
8. WHEN WAS YOUR LAST COMPLETE PHYSICAL?
9. WOMEN ONLY: A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? YES NO B) ARE YOU NURSING? YES NO C) ARE YOU TAKING BIRTH CONTROL PILLS? YES NO

- 10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.
HIGH BLOOD PRESSURE HEART DISEASE CHEST PAINS KIDNEY DISEASES
HEART ATTACK CARDIAC PACEMAKER EASILY WINDED AIDS OR HIV INFECTION
RHEUMATIC FEVER HEART MURMUR STROKE THYROID PROBLEM
SWOLLEN ANKLES ANGINA HAY FEVER / ALLERGIES HEPATITIS / JAUNDICE
FAINTING / SEIZURES FREQUENTLY TIRED TUBERCULOSIS SEXUALLY TRANSMITTED DISEASE
ASTHMA ANEMIA RADIATION THERAPY STOMACH TROUBLES / ULCERS
LOW BLOOD PRESSURE EMPHYSEMA GLAUCOMA RESPIRATORY PROBLEMS
EPILEPSY / CONVULSIONS CANCER RECENT WEIGHT LOSS OTHER
LEUKEMIA ARTHRITIS LIVER DISEASE
DIABETES JOINT REPLACEMENT OR IMPLANT HEART TROUBLE

COMMENTS

PATIENT DENTAL HISTORY

- PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?
A) CLICKING?
B) PAIN (JOINT, EAR, SIDE OF FACE)?
C) DIFFICULTY IN OPENING OR CLOSING?
D) DIFFICULTY IN CHEWING?
8. DO YOU HAVE FREQUENT HEADACHES?
9. DO YOU CLENCH OR GRIND YOUR TEETH?
10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY?
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?
12. HAVE YOU HAD ANY ORTHODONTIC WORK?
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?

I certify that I have read and understand the above information, to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X
PATIENT, PARENT OR GUARDIAN DATE

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_

Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_

Street Apartment #

City State Zip Code

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code Phone

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

# Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Lawrence K. Banker, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Lawrence K. Banker, DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

### ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
SPOUSE ONLY	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
OTHER (PLEASE SPECIFY):	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

### OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement Not obtained			
PROVIDED PRIOR TO TREATMENT?	YES	<input type="checkbox"/>	DATE STATEMENT PROVIDED: _____
	NO	<input type="checkbox"/>	
REASON FOR NOT OBTAINING SIGNATURE	<input type="checkbox"/>	NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES	
	<input type="checkbox"/>	WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING STATEMENT	
	<input type="checkbox"/>	UNABLE TO SIGN	
	<input type="checkbox"/>	REASON NOT GIVEN	
Lawrence K. Banker, DDS 200 Little Falls Street, Suite 101 Falls Church, Virginia 22046			

# STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

## Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Virginia. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

## Collecting Protected Health Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

## Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

## Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

Please ask if you have any questions about your privacy rights or the protection of your health information.

Lawrence K. Banker, DDS \* 200 Little Falls Street, Suite 101 \* Falls Church, Virginia 22046 - 703-237-7725