Advanced Dental Solutions LLC.
www.fallschurchdentistry.com
7115 Leesburg Pike Suite 304 Falls Church, VA 22043
P: (703) 237-2932

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name: ____________________ ____________________ ___ ____________________
Last First MI Preferred Name

Title: __________ Gender: ○ Male ○ Female Family Status: ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: __________ Prev. Visit: __________ Email Address: ____________________

Phone: __________ __________ __________ ______ Best time to call: __________
Home Mobile Work Ext

Address: ____________________ ____________________
Address 1 Address 2

____________________ __________ __________
City State Zip Code

Social Security Number: __________

Date of last Dental visit: __________

Name of person, office, or other source referring you to our practice:

Occupation: ____________________________________ Company Name: _______________________________Phone # __________

Responsible Party Information

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: ____________________ ____________________ ___ ____________________
Last First MI Preferred Name

Title: __________ Gender: ○ Male ○ Female Family Status: ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: __________ Email Address: ____________________

Phone: __________ __________ __________ ______ Best time to call: __________
Home Mobile Work Ext

Address: ____________________ ____________________
Address 1 Address 2

____________________ ______ __________ _____-____
City State Zip Code

If the Emergency Contact is different from the Responsible Party listed above, please provide their Name, Gender, Phone Number and Relationship to the patient.

Primary Insurance Information

Primary Dental Insurance:

Name of Insured:

______________________ ______________________ ____
Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ ____-____
City State Zip Code

Insured's Employer Name: ______________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ ____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ ____-____
City State Zip Code

If you have secondary insurance, what is the plan name and who is the subscriber?

____

____

Check all that apply, please do not leave any blank.

Condition			Condition		
Allergies *	◯ Yes	◯ No	Amoxicillin Allergy *	◯ Yes	◯ No
Asthma *	◯ Yes	◯ No	Cancer *	◯ Yes	◯ No
Cardiac Pacemaker *	◯ Yes	◯ No	Clindamycin Allergy *	◯ Yes	◯ No
Codeine Allergy *	◯ Yes	◯ No	Diabetes *	◯ Yes	◯ No
HIV *	◯ Yes	◯ No	Hay Fever *	◯ Yes	◯ No
Heart Disease *	◯ Yes	◯ No	Hepatitis *	◯ Yes	◯ No
High Blood Pressure *	◯ Yes	◯ No	Hyperthyroidism *	◯ Yes	◯ No
Ibuprofen Allergy *	◯ Yes	◯ No	Joint Replacement *	◯ Yes	◯ No
Kidney Disease *	◯ Yes	◯ No	Latex Allergy *	◯ Yes	◯ No
Mental Disorders *	◯ Yes	◯ No	Nervous Disorders *	◯ Yes	◯ No
Pacemaker *	◯ Yes	◯ No	Penicillin Allergy *	◯ Yes	◯ No
Pregnancy *	◯ Yes	◯ No	Radiation Treatment	◯ Yes	◯ No
Seizures * *	◯ Yes	◯ No	Sinus Problems	◯ Yes	◯ No
Stroke *	◯ Yes	◯ No	Tuberculosis *	◯ Yes	◯ No
Tumors *	◯ Yes	◯ No		◯ Yes	◯ No
Venereal Disease *	◯ Yes	◯ No			

Please list any medications you are currently taking, one medication per line:

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

If yes, please explain:

Consent for Services / Office Policies

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any 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 1.5% per month on the unpaid balance will be charged on all accounts exceeding 60 days, and will send to collection agency, unless previously written financial arrangements are satisfied.

I understand that any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 to discuss this statement or my treatment.

I understand that a 24-hour notice must be given for the cancellation of any appointment, failure to do so will result in a fee charged to my account based on the length of appointment. From $50 for short appointments to $100 for long appointments.

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

Patient Signature:

Date: ___________

Advanced Dental Solutions LLC
Cancellation Policy and no-show policy

At Advanced Dental Solutions, our goal is to provide high-quality care to all our patients in a timely manner. To ensure that we can accommodate everyone, we have established the following cancellation and no-show policy.

Appointment Cancellation policy: We kindly request that you provide at least 24 hours' notice if you need to cancel or reschedule your appointment. Cancellation made with less than 24 hours' notice may result in a cancellation fee of **$50**, which will be charged to the card on file. Exceptions may be made for emergencies or extenuating circumstances at the discretion of our office.

No-Show Policy: If you do not show up for you scheduled appointment without prior notification, it will be considered a "no-show". Patients who fail to attend their appointment without notice may be a charged a no-chow fee of **$50** which will be charged on the card on file.

Late Arrival Policy: If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule. In some cases, a late arrival may be considered a no-show, and fees may apply.

Long Procedure Cancellation policy: We kindly request that you provide at least 24 hours' notice if you need to cancel or reschedule your procedure. Cancellations made with less than 24 hours' notice may result in a cancellation fee of **$100,** which will be charged to the card on file. Exceptions may be made for emergencies or extenuating circumstances at the discretion of our office.

Acknowledgment and Agreement:

By scheduling an appointment with Advanced Dental Solutions LLC, you acknowledge and agree to this cancellation and no-show policy

Patient's Name: ____
Patient's Signature: ____
Date: ____

HIPAA Notice of Privacy Practices

Advanced Dental Solutions
7115 Leesburg Pike Suite 304
Falls Church, Virginia 22043

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control you protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

Uses and Discloses of Protected Health Information.

Your protected health information may be used and disclosed by your physicians, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and may use other required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care. and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. Another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to, qualify' assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when you physician is ready to see you. We try use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversi2ht•. Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors. and Organ Donation: Research: Criminal Activity: Military Activity and **National Security:** Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine out compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You may request this authorization, at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights. Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family member or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclose of you protected health information, your protected health information with not be restricted. You then have the right to use another Healthcare Professional.

You may have the right to request to receive confidential communication from us by. alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively electronically.

You may have the right to have your physician amend you protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made from your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledged that you have received this Notice of our Privacy Practices:

Name: __________________________ **Signature:** ________________________________ **Date:** ______________