Oral & Facial Surgery Center of Virginia
3787 Fettler Park Dr A8, Dumfries, VA 22025
(703) 574-4717
www.virginiaoralfacialsurgery.com

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DENTAL INSURANCE INFORMATION
| DOB:

Created at: **11/07/2024 11:30:36 AM**

Primary Insurance Information

Do you have a dental insurance?	
Would you like to upload insurance card photo?	
Patient’s relationship to the Insurance Holder	
Insurance Holder's name	
Insured Date of Birth	
Insured Address	
Insured Address	
Insured City	
Insured State	
Insured ZIP	
Insured Employer’s Name	
Dental Insurance Company	
ID Number	
Group Number	
Insurance Plan Name	
Insurance Company Contact	

Secondary Insurance Information

Do you have a secondary dental insurance?	
That's all! If you would like to add secondary insurance, you need to provide primary insurance first.	
Would you like to upload insurance card photo?	
Patient’s relationship to the Insurance Holder	
Insurance Holder's name	
Insured Date of Birth	
Insured Address	
Insured Address	
Insured City	
Insured State	
Insured ZIP	
Insured Employer’s Name	
Dental Insurance Company	

ID Number	
Group Number	
Insurance Plan Name	
Insurance Company Contact	

Medical Insurance

Do you have Medical Insurance?	
What is the policy holder's Name	
What is the policy holder's date of birth ?	
ID number	
Group Number	
Insurance Plan Name	
Insurance Company Contact	
Patient's Relationship to the Insurance Holder	
Would you like to upload insurance card photo?	

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HEALTH HISTORY
| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

General Health Information

Are you currently under the care of a physician?	
Have you been vaccinated for COVID-19?	
Physician phone number	
Date of last physical exam	
Current weight	
Current Height	
Are you pregnant or recently had a baby?	
Are you currently breastfeeding?	
Are you presently being treated for any injury or illness?	
Have you ever been hospitalized for an injury or illness?	
Have you ever had a surgical procedure?	
Are you an Organ Recipient?	
Are currently taking any medications?	
Are you required to pre-med with antibiotics before dental treatment?	
History of illicit Drug use / Marijuana/ Alcohol, or Other Drug Dependency?	
Do you use or have you ever used tobacco?	
Do you have allergies to any medication?	

Medical Conditions

Please check all conditions that you have history of or are currently being treated for	
Do you have a history or are currently being treated for any Digestive conditions?	
Do you have a history or are currently being treated for any Heart or Circulatory conditions?	
Do you have a history or are currently being treated for any Neurological conditions?	
Do you have a history or are currently being treated for any Lung or Breathing conditions?	
Do you have a history or are currently being treated for any Autoimmune conditions?	
Head or neck injuries?	
Artificial Joint?	

High cholesterol?	
History of cancer?	
Tumor or abnormal growth?	
Radiation therapy?	
Chemotherapy?	
HIV / AIDS?	
Osteoporosis / osteopenia?	
Type I or Type II diabetes?	
Anemia?	
Kidney disease?	
Liver disease?	
Thyroid disease?	
Tuberculosis / measles / chicken pox?	
Recipient of Organ Transplant?	
Any other medical condition we should know of?	

Medications

Please check all medications you are currently taking	
Are you taking any pain medications?	
Are you taking any Antidepressants or Anxiety medications?	
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	
Are you taking any Allergy or Asthma medications?	
Are you taking any Antibiotics?	
Are you currently taking any other medications or dietary supplements?	

Patient's signature: Date:

Doctor's signature: Date:

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NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Basic Information

What pharmacy are you currently using?	

Patient's signature: Date:

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PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

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FINANCIAL POLICY

1. Payment for services rendered is due the day of the appointment.
2. OFS assists with filing insurance; however, the Patient or Parent/Guardian is directly responsible for payment in full of any and all fees not paid for by the insurance company. When treatment co-pays and fees are quoted by the office, these are estimates only; your actual insurance coverage may be less or more. The insurance company is unable to provide the exact amount that will be paid until the claim is processed.
3. Personal checks that are returned due to insufficient funds are subject to a $45.00 NSF fee.
4. **Missed appointments and appointment cancellations with less than 72 hours (3 business days) notice are subject to a cancellation fee of $200.00 for any appointment scheduled for 30 minutes and appointments scheduled for one (1) hour or longer are subject to a $500.00 cancellation fee.**
5. All accounts over 60 days are considered past due. Such accounts are subject to 1.5% monthly finance charges. Past due accounts may be sent to an authorized collection agency. Accounts sent to a collection agency will be assessed a 30% collection charge on the unpaid balance. The Parent/Guardian will also be liable for any applicable attorney fees and court costs. Accounts that have been referred to an outside collection agency will be placed on a CASH ONLY basis for any future treatment.
6. We are required by the State of Virginia to keep patient records for three years past the final date of treatment. If you are moving or leaving the practice for any reason you may request a copy for your records. There may be a minimal charge for the release of your records.
7. I understand that the fee estimate listed for this dental care is only good for a period of six (6) months from the date of the patient examination.
8. All emergency dental services must be paid for at the time services are performed.
9. I authorize payment of dental insurance benefits payable to OFSC of VA, unless payable to me directly per the Insurance Plan.
10. I authorize the release of any information relating to any insurance claims to the relevant insurance company.

I, as the Responsible Party, acknowledge that I have read all of the above information and that I understand it completely.

Patient's signature: Date:

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Oral & Facial Surgery Center of Virginia offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Oral & Facial Surgery Center of Virginia will use reasonable means to protect the security and confidentiality of email information sent and received. However, Oral & Facial Surgery Center of Virginia cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Oral & Facial Surgery Center of Virginia and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Oral & Facial Surgery Center of Virginia.

Patient's signature: Date:

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Oral & Facial Surgery Center of Virginia, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Oral & Facial Surgery Center of Virginia will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Oral & Facial Surgery Center of Virginia cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Oral & Facial Surgery Center of Virginia and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Oral & Facial Surgery Center of Virginia.

Patient's signature: Date: