# Culpeper Family Dental

Welcome!
540-825-1366

1701 Sunset Lane
Culpeper, VA 22701

*We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.*

## Patient Information

**Name** _____ **Date of Birth** _____

**Soc. Sec. #** _____ *not required for children*

**Address** _____ **City/State/Zip** _____

**Home Ph#** _____ **Cell Ph#** _____ **Email:** _____

**CHECK ONE** ☐Male ☐Female

**Emergency Contact Name** _____ **Ph#** _____

**MINOR PATIENTS: Responsible Party MUST BE PRESENT (we will not bill third party)**

**Responsible Party:** _____ **Ph#** _____ **Employer** _____

**Dental Insurance Name/Group Number:** _____

**Subscriber ID #:** _____ **Subscriber DOB:** _____

## Medical History

**Please list any medications:**

_____
_____
_____
_____
_____

**Please list any allergies:**

_____
_____
_____
_____
_____

Physician name _____ Location _____ Ph# _____
Date of last visit _____ Pharmacy _____
**WOMEN**: Are you pregnant? ☐ No ☐ Yes if yes, Due Date _____ Are you nursing? ☐No ☐ Yes
Are you currently taking birth control? ☐No ☐ Yes
Any serious illness or operations? ☐No ☐Yes, If yes, describe _____
Have you ever had a blood transfusion? ☐No ☐ Yes If yes, give appx. dates _____
☐

Have you ever taken Fen-Phen/Redux? ☐No Yes

Have you ever used a bisphosphonate medication? No Yes *(EG: Fosamax, Actonel, Atelvia, Didronel, Boniva)*

Please check if have had any of the following:

- ☐ AID/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ *Describe Heart Problems*_____

_____

- ☐ Hemophilia/Abnormal Bleeding
- ☐ Herpes
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaw pain
- ☐ Kidney disease, malfunction
- ☐ Liver disease
- ☐ Material allergies *(latex, wool, metal, chemicals)*
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker/Heart surgery
- ☐ Psychiatric care
- ☐ Rapid weight gain or loss
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic/Scarlet fever
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Spina bifida
- ☐ Stroke

- ☐ Surgical implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease or malfunction
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer/Colitis
- ☐ Venereal disease

Other:_____

_____

_____

_____

_____

_____

_____

_____

_____

# Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the use of this signature on all insurance submissions.

I authorize Culpeper Family Dental, PC to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

# Culpeper Family Dental, PC
# Financial Policy

Welcome! Thank you for choosing us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

**FINANCIAL AGREEMENT:**
Patients are expected to pay for services at time they are rendered. We strive to give you a comprehensive treatment plan and the cost of that treatment prior to doing any dental work, however, treatment can change. There will be a fee for any additional procedure NOT included in the original treatment plan.

**PAYMENT METHODS ACCEPTED** Payments may be made using cash, personal check, Visa, MasterCard, flex spending cards(FSA/HSA), American Express, and/ or Discover. We also offer CARECREDIT, a financing option that is available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance. There will be a $25 late fee charge after 30 days. Accounts over 90 days are subject to our collection agency.

For minor patients, the responsible party for the account **MUST BE PRESENT.** If the minor has insurance through a person not present, we will inform you of the information required by our office to bill the insurance company, **WE WILL NOT BILL A THIRD PARTY THAT IS NOT PRESENT TO SIGN THIS FINANCIAL POLICY.**

**APPOINTMENTS:**
**In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system.**
**In order to do this, a confirmation is REQUIRED by 1pm the day prior to your appointment in order to honor your scheduled appointment time. You may confirm by calling the office or replying "1" to the text message the system sends to your mobile phone.**

**Unfortunately, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least a 24 hour notice for any canceled appointment. There is a $50 fee for same day canceled appointments and $50 fee to rebook a no show appointment. _____–Please Initial**

**INSURANCE INFORMATION:**
As a courtesy to our insured patients, we submit claims to your insurance company free of charge. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance may not run January-December). If your insurance plan changes please let us know as soon as possible. We will work with you and the insurance company to maximize your dental benefits.

**THE DENTIST WILL DIAGNOSE TREATMENT BASED ON YOUR DENTAL HEALTH, NOT YOUR INSURANCE COVERAGE.**

**YOU MUST REALIZE THAT:**

Dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a dentist may recommend a crown for tooth that has extensive decay; however, the dental plan may only cover the cost of filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling.

**Participating Insurance:** As a participating insurance provider, we will estimate your copayment and file insurance claims for treatment. Your **estimated copayment is due at the time of service.** Your insurance company will processes and finalize the claim once they receive it, in some instances resulting in a credit or balance. We will contact you regarding any credit and reimburse you, or you may choose to keep the credit on your account for future treatment. A bill will be mailed for any remaining balances; Financial Agreement applies, please refer back to that section.

**Non-participating Insurance**: The courtesy explained above is extended to you. **Your estimated copayment is due at the time of service.** If your insurance company has not paid within 90 days of services rendered, you will need to make full payment to this office and be reimbursed when your insurance company pays. Any treatment you receive that is not covered by your insurance plan for any reason is your responsibility. Financial Agreement applies.

**Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the financial policy also shall cover your dependent children who are patients of the practice.**

_____

**Patient(s) name PLEASE PRINT**

_____

**Responsible party signature (& PRINT if other patient) Date**

_____

**Date of Birth of Responsible party SSN of Responsible party**

## Culpeper Family Dental, PC

## *HIPAA PATIENT CONSENT FORM*

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law.

You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting the office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**The Patient understands that:**

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day for service payment in full for any services will be required.

- List all phone numbers that are approved for detailed voice messages:

_____

- List all phone numbers that are approved for appointment reminders and other information:

_____

I give my permission to discuss my treatment and/or billing information with:

_____ _____

**Name** **Relationship to Patient**

***If no one, leave blank & sign consent***

**This HIPAA Consent was signed by:** Printed Name: _____

Signature: _____ Date: _____

Relationship to the Patient (*if other than patient*): _____