Karis Dental
4290 Chain Bridge Road, #202 Fairfax, VA 22030
Phone: (703) 828-6630 Fax: (888) 636-8702
EmaiL: KarisDental.Info@gmail.com
Website: www.Karis-Dental.com

WELCOME to Karis Dental

Thank you for selecting our dental health team. We look forward to working with you in maintaining and improving your dental health.

PATIENT INFORMATION FORM (CONFIDENTIAL)

Today's Date: _____ Gender: ❑ Male ❑ Female

Name: _____ Preferred Name: _____
Last First M.I.

Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birthdate: _____ Driver's License #: _____

Cell Phone #: _____ Alternate Phone #: _____

Email: _____

I am: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

EMERGENCY CONTACT INFORMATION

Full Name: _____ Relationship: _____ Cell Phone #: _____

HOW DID YOU HEAR ABOUT US?

Whom may we thank for referring you? _____

BEST METHOD TO CONTACT YOU?

( ) Home Phone ( ) Cell Phone ( ) Work Phone ( ) Email ( ) Text

DENTAL INSURANCE: ❑ I do not have dental insurance

Insurance Company: _____

Subscriber's Name:_____ Subscriber's Birthdate: _____

Policy ID #: _____ Group #: _____

Name of Employer: _____ Occupation: _____

Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Stepchild ❑ Other: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

PATIENT SIGNATURE: _____

MEDICAL HISTORY

Do you have or have you had **Any** of the following?

Yes **No** (Please check any that apply):

- ❑ ❑ Asthma
- ❑ ❑ ADD / ADHD
- ❑ ❑ Autism
- ❑ ❑ AIDS / HIV
- ❑ ❑ Anemia: ❑ Sickle Cell ❑ Iron Deficient
- ❑ ❑ Arthritis: _____
- ❑ ❑ **Bleeding Issues: ❑ Prolonged**
- ❑ ❑ **Blood Pressure**: **❑ High ❑ Low**
- ❑ ❑ Bruise Easily
- ❑ ❑ Cancer / Leukemia
- ❑ ❑ Cardiac Pacemaker
- ❑ ❑ Chest Pains (Angina)
- ❑ ❑ Cold Sores / Fever Blisters
- ❑ ❑ **Diabetes**
- ❑ ❑ Fainting / Seizures
- ❑ ❑ Frequently Tired / Easily Winded
- ❑ ❑ Glaucoma / Eye issues
- ❑ ❑ **Heart Disease**
- ❑ ❑ **Heart Valve Replacement**
- ❑ ❑ Hepatitis / Jaundice
- ❑ ❑ Joint Replacement / Implant
- ❑ ❑ Kidney disease
- ❑ ❑ Lung Issues: ❑ Emphysema ❑ Bronchitis ❑ COPD
- ❑ ❑ Migraine headaches / Frequent headaches
- ❑ ❑ Neurologic Condition
- ❑ ❑ Nervousness
- ❑ ❑ Respiratory Problems
- ❑ ❑ **Radiation / Chemotheray**
- ❑ ❑ Rheumatic Fever / Rheumatic Heart Disease
- ❑ ❑ Recent Weight Loss
- ❑ ❑ Sexually Transmitted Disease
- ❑ ❑ **Sinus Issues**
- ❑ ❑ Sleep Apnea / Breathing Disorder
- ❑ ❑ Sleeping Disorder
- ❑ ❑ **Stroke**
- ❑ ❑ Stomach Trouble / Ulcers
- ❑ ❑ Tuberculosis
- ❑ Other: _____

_____

Do you smoke? ❑ Yes ❑ No

Do you chew tobacco? ❑ Yes ❑ No

Allergies to, or have you reacted adversely to any of the following?

Yes **No** (Please check any that apply):

- ❑ ❑ Aspirin
- ❑ ❑ Acetaminophen (Tylenol)
- ❑ ❑ Any metals (Nickel, Mercury, etc.)
- ❑ ❑ Barbiturates, Sedatives, or Sleeping Pills
- ❑ ❑ Codeine or other Narcotics
- ❑ ❑ Ibuprofen (Advil, Motrin, Alleve, Naproxen, etc.)
- ❑ ❑ Iodine
- ❑ ❑ Local anesthetics ("Novocaine")
- ❑ ❑ Latex Rubber
- ❑ ❑ Penicillin or otherAntibiotics_____
- ❑ ❑ Sulfa Drugs
- ❑ ❑ Other:_____

Are you taking any of the following **Medication(s)**?

Yes **No** (Please check only that apply):

- ❑ ❑ Aspirin
- ❑ ❑ Anticoagulants (Blood Thinners)
- ❑ ❑ Penicillin, other Antibiotics or Sulfa Drugs
- ❑ ❑ Pain Medicines: _____
- ❑ ❑ High Blood Pressure Medicine
- ❑ ❑ Antidepressants or Tranquilizers
- ❑ ❑ Insulin, Orinase, or other Diabetes Drug
- ❑ ❑ Nitroglycerin
- ❑ ❑ Cortisone or other Steroids
- ❑ ❑ Osteoporosis (Bone Density) Medicine

Please List any medications with dosages and frequencies:

_____

_____

Women Only:

Yes **No** (Please check only that apply):

- ❑ ❑ Are you Pregnant or do you think you may be?
  Expected delivery date: _____
- ❑ ❑ Are you Nursing?
- ❑ ❑ Taking Birth Control Pills? / Taking Hormones?

Note: Antibiotics (i.e. Penicillin) may alter the effectiveness of birth control pills. Consult your Physician or Gynecologist for assistance regarding additional or alternative methods of Birth Control.

Are you currently under the care of a doctor? ❑ Yes ❑ No

Have you been hospitalized or had surgery in the last 5 years? ❑ Yes ❑ No

Physician's Name: _____

Physician Phone #_____

Date of Last Medical Exam: _____

Do you have any diseases, conditions, or problems not listed above?_____

PATIENT NAME: _____

DATE OF BIRTH: _____

PATIENT SIGNATURE: _____

DENTAL HISTORY

Who was your previous Dentist:_____ Date of Last Dental Exam: _____

Reason for today's visit?_____

_____

1. Have you ever had any unfavorable experience from previous dental offices?	❑ Yes	❑ No	If Yes, please explain: _____
2. Have you ever had gum disease?	❑ Yes	❑ No	
3. Do your gums bleed?	❑ Yes	❑ No	If Yes, please explain: _____
4. Are you in pain now or think you have a cavity?	❑ Yes	❑ No	If Yes, where? _____
5. Are you pleased with the appearance of your teeth?	❑ Yes	❑ No	If No, why? _____
6. Are you interested in whiter teeth?	❑ Yes	❑ No	If Yes, please explain: _____
7. Do you have sensitive teeth	❑ Yes	❑ No	If So, is it to: ❑ Sweets ❑ Hot ❑ Cold
8. Do you have pain elsewhere in your face or jaws?	❑ Yes	❑ No	If Yes, where? _____
10. Does food collect between your teeth?	❑ Yes	❑ No	If Yes, where?_____
11. Do you think you have bad breath?	❑ Yes	❑ No	
12. Are you missing any teeth?	❑ Yes	❑ No	
13. Do you have any old filling or previous dental treatment that is no longer satisfactory to you?	❑ Yes	❑ No	If Yes, where?_____
14. Are you interested in braces?	❑ Yes	❑ No	

15. Please use the space below and let us know what you would like from us as your dental provider and any other concerns or questions you have regarding your appointment:

_____

_____

I, the undersigned, do affirm that the above information is correct and I do give consent to agreed upon dental services, and use of medically and dentally necessary treatment moving forward. To the best of my knowledge, all of the preceding answers on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health and may compromise my dental treatment. It is my responsibility to inform the dental office of any changes in my medical status. If I have any changes in my health status or if my medication(s) change, I shall inform the dentist and staff at the next appointment without fail.

Signed:_____ Date:_____/_____/_____

(Patient or Guardian Signature)

Karis Dental
4290 Chain Bridge Road, #202 Fairfax, VA 22030
Phone: (703) 828-6630 // Fax: (888) 636-8702 // Email: KarisDental.Info@gmail.com // Website: http://www.karis-dental.com

OFFICE POLICY

INSURANCE COVERAGE: We are participating providers with numerous insurance companies. This does change periodically. You may wish to inquire regularly as to our participation with your plan. We are not required to notify you of changes in our Participation status with your benefit plan. By signing all the necessary forms at the time of your registration we can file your Insurance claims for you. Advise us of any and all dental coverage you may have. Refusal to sign any necessary forms may Result in us being unable to submit for insurance benefits on your behalf. Please be aware that as dental providers our relationship is with you, not your insurance company. Problems regarding your insurance and coverage must be resolved between you and your insurance carrier. It is your responsibility to be informed and educated as to the coverage available under your policy. You are responsible for providing all information to us regarding your insurance coverage and identify as well as proper legal proof of such (ex: Insurance card, Government issued identification card, Driver's License, etc.).

PAYMENT: From the information given by your insurance company we will do our best to calculate the patient portion for services rendered or proposed. No treatment estimate given by us is a guarantee and no benefits can be calculated until services are performed and your claim is adjucated by your carrier. We will not adjust charges or diagnostic codes after services are rendered. If your insurance carrier denies payment, you will be billed for the amount they determine you to be responsible for and for the amount we are allowed to bill under Virginia's insurance regulations. Payment is due upon receipt of statements. In the event that we appeal your insurance carrier's decision, we may still require you to pay the outstanding portion and you will be eligible for reimbursement upon adjucation and outcome of any insurance appeal. We do not offer in-house payment arrangements. Accounts over 90 days will be turned over to a collection agency or an attorney for legal action. Charges associated with these actions will be the responsibility of the patient.

CANCELLATIONS: We require **72 business hours notice** for cancellations. Appointment cancellations left on our answering machine Will not be considered received until the business opens on the following regularly scheduled business day. Please plan accordingly And call well in advance if you need to change your appointment. There is a $100 per scheduled hour charge for any broken Appointments not cancelled or rescheduled within the time frame stated above. This charge is not billable to your insurance and will be required to be paid before scheduling your next appointment. We recognize that from time to time, unavoidable circumstances may result in a cancelled or broken appointment with little or no notice. We reserve the right to decide whether or not to charge for missed appoinments on a case by case basis.

SCHEDULED APPOINTMENT TIMES: We schedule appointments for a set amount of time based on how long it takes to perform each procedure. We do not double book our appointments. In order for you to receive the best possible care and be seen on time, please come early and ready for your appointment at the scheduled time. Being late or unprepared may result in changes to your appointment or rescheduling. Our office required that at time of scheduling for services, you reserve your appointment with a payment of 25% of your estimated patient cost. If you cancel with less than 72 business hours notice, any cancellation fees may be billed against the 25% down payment.

FILLINGS: Our practice does not use metal (amalgam / Mercury) for fillings. We offer tooth-colored (composite resin / "white") fillings. Many insurance plans offer an alternate benefit for tooth-colored fillings. This means your insurance company may only pay what they would have paid towards a metal filling. If this is the situation, you are responsible for the difference between the fee of the metal filling and the tooth-colored filling.

TO RECAP:

1. Your insurance benefits and payments are between you and your insurance carrier.
2. 25% of your patient portion is due at time of scheduling any appointment (not regular cleaning).
3. The remainder of your patient portion is due at time of service.
4. We have a 90 days to pay any statements before they are subject to collections.
5. We require 72 hours notice on all cancelled and rescheduled appointments. We charge a $100 per scheduled hour cancellation / no-show fee for appointments that do not meet the required 72 hours notice.
6. You must be on time and ready for your appointment.
7. We only do tooth-colored fillings and you may be responsible for the fee difference.

Patient Name: _____ Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ("HIPPAA")

Effective Date of Notice: _____/_____/20____

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

We respect your legal obligation to keep health information that identifies your privacy. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose our health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and taxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have sen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how e use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons; we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or dislcosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Adminstration regarding drugs or medical devices.
- Disclosures to governmental authorities about vicitms of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
- Disclousre to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations.
- Uses or disclosures for health related research.
- Uses and disclosures to prevent a serious threat to health or safety.
- Uses or disclosures for specialized government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service.
- Disclosures of de-identified information.
- Disclosures relating to worker's compensation programs.
- Disclosures of a "limited data set" for research, public health, or health care operations.
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures.
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with our dental care.

APPOINTMENT REMINDERS

We may call, text, email or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, text, email or write to notify or write to notify you of other treatments or srvices available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a text, email or a phone message or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The contents of an "authorization form" is determined by fedral law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometime, you may initiate the authorization process if the use or disclosure is our idea. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your halth information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax, text or email shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information wihin 30 days of asking us (or sixty days if the information is

tored off-site). You may have to pay for photocopes in advance. If we deny your request, we will send you a written explanation, and instructions aobut how to get an impartial review f our denial if one is legally availab.e By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review of get photocopies of your health information, send a written request to the office contact person a the address, fax, text or email shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your halth information along with any rebuttal statement that we may write. Once you statement of position an/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax, text or email shown at the beginning of the Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: isclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days or receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax, text or email shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in peper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax, text or email shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this Notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new Notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, text or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in peron of this Notice.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Protability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient Name Relationship to Patient

_____ _____

Signature Date