

MAIN STREET DENTAL GROUP

COSMETIC • IMPLANT FAMILY DENTISTRY

formerly *Jamie Park DDS & Associates*

10680 main street #150
fairfax, va 22030
703 . 385 . 4569
703 . 665 . 0664 fax
mainstreetdentalgroup.com

1

Personal Information

Patient's Last Name _____ First Name _____ Middle Initial _____

Preferred Name / Nickname _____

Patient Sex: Male Female

Date of Birth _____ Social Sec. Number _____

Home Address _____

City _____ ST _____ ZIP _____

Name of Employer (or school) _____ Occupation (or field of study) _____

Employer's Address (or school address) _____

Marital Status: Married Unmarried

Full Name of Spouse _____ Spouse's Employer (Name & City) _____

Spouse's Work Tel. _____

Cell Number : _____

Home Number : _____

Work Number : _____

E-mail : _____

Who may we thank for referring you to our office?
(or please tell us how you heard of us)

Which other family members are patients at this office?

Insurance Information

Subscriber's Name (e.g. name of head of household) _____ Name of Subscriber's Employer _____

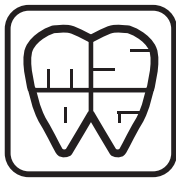
Subscriber's Date of Birth _____ Subscriber's Soc. Sec. Number _____ Subscriber's Relationship to Patient (e.g., self / spouse) _____

Insurance Company & Plan Name _____ Group ID Number _____ Subscriber ID Number _____

Emergency Contact Information

Name of Emergency Contact _____ Relationship to Patient _____

Home Telephone Number _____ Work Telephone Number _____ Cell or Other Telephone Number _____



Patient Medical & Dental Information Form

2

Patient's Last Name _____ Patient's First Name _____ Middle Initial _____

Dental History & Cosmetic Treatment Options

Date of Last Dental Visit: _____ Former Dentist: _____
 Date of Last X-rays: _____ ... in City, State: _____

- Yes No Do you feel that your mouth (or jaw) functions properly?
- Yes No Are you happy with the appearance of your teeth/smile?
- Yes No Are all of your teeth in alignment (straight)?
- Yes No Do you have any old fillings, crowns, or dental treatment(s) that you are concerned about or unhappy with?

If you could, what would you like to change about your teeth/smile? _____

Please let us know if you would like information about any of the following:

- Invisalign (clear braces) Porcelain veneers Whitening / Bleaching Making teeth look taller Closing gaps between teeth

- Yes No Are you fearful of dental treatments?

If YES, rate your fear level from 1 (some fear) to 10 (incredibly fearful) _____

What is the trigger for your fear? (check all that apply) Needles Smells Sounds Fear of pain

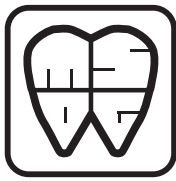
Check if you have had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal (gum) treatment |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding/clenching teeth | <input type="checkbox"/> Prolonged bleeding after extraction |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sensitivity to biting/chewing |
| <input type="checkbox"/> Difficult opening or closing of jaw | <input type="checkbox"/> Jaw pain or tiredness | <input type="checkbox"/> Sensitivity to cold/hot/sweets |
| <input type="checkbox"/> Difficult extractions in the past | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sores, lumps, growths in your mouth |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Swollen or tender gums |

Medical History

Date of Last Physician Visit: _____ Name of Physician: _____
 ... in City, State: _____ Tel. No.: _____

- Yes No Have you had any serious illnesses, operations, or hospitalizations? If YES, please give dates and reason: _____
- Yes No Have you ever had a blood transfusion? If YES, please give dates and reason: _____



MAIN STREET DENTAL GROUP

COSMETIC • IMPLANT FAMILY DENTISTRY

formerly *Jamie Park DDS & Associates*

10680 main street #150
fairfax, va 22030
703 . 385 . 4569
703 . 665 . 0664 fax
mainstreetdentalgroup.com

3

Check any of the following which apply to you:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis - Type: _____ | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough -- Persistent or Bloody | <input type="checkbox"/> Herpes / Cold Sores (blisters) | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes -- Type (1 or 2): _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arthritis -or- Rheumatism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Skin Rash / Hives |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints/Replacements | <input type="checkbox"/> Fainting / Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hay Fever / Seasonal Allergies | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemical / Drug Addiction | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Murmurs / Irregular Beat | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Other: _____ |

Medications you are currently taking: (including over-the-counter)

Women only:

- Yes No Are you currently pregnant?
(or think that you might be?)
- Yes No Are you nursing?

Tobacco user?

- Yes No

What kind, how many years, how often? _____


Are you currently taking or have you taken any of the following?

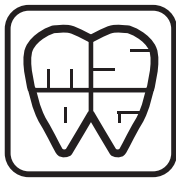
- | | |
|---|----------------------------------|
| <input type="checkbox"/> Fen-Phen/Redux | <input type="checkbox"/> Actonel |
| <input type="checkbox"/> Boniva | <input type="checkbox"/> Fosomax |

Vitamins / Minerals / Supplements / Herbal:

Allergies:

- | | | |
|---|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Antibiotics (e.g. Penicillin) |
| <input type="checkbox"/> Barbiturates (e.g. sleeping pills) | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetic (e.g. Novocaine) | <input type="checkbox"/> Others: _____ |

Continue on to next page... 



Insurance Benefits and Claims Policy


GENERALLY: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, or if your insurance company has not paid your account in full within 60 days from the date the services were rendered, the balance will become payable immediately, regardless of any pending claims. We require that your complete insurance information be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

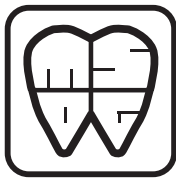
MAINTAINING HIGH STANDARDS FOR CARE: Please be aware that some, and perhaps all, of the services provided may be non-covered services, or may have a charged fee not considered "reasonable and customary", or may be deemed an unnecessary service according to administrators of your insurance policy. The decision(s) of your insurance policy's administrators, particularly regarding the necessity of treatment, are outside of our control. Our practice is committed to providing the best dental care for you, determined by professional and skilled dentists examining you, rather than administrators examining charts and figures about your or the service rendered. Also, we strive to maintain the highest standards in terms of sterilization, materials and laboratory services for our patients. As such, we choose not to allow administrators of insurance policies to compromise our level of care or standards, and trust that our patients appreciate our efforts in this regard. Therefore, each patient joining our practice agrees to be responsible for paying their full balance, less insurance payments received, despite any insurance company's determination regarding the necessity or usual and customary fees charged for services rendered at our office.

FILING CLAIMS: As a courtesy to our patients, we will do our best to verify your dental insurance benefits and also answer any questions you may have about insurance claims. However, each patient is responsible for knowing their insurance plan's coverage, exclusions, limitations and usage history. Furthermore, each patient should be aware of non-covered benefits, including missing tooth clauses, crown/bridge/denture restoration time and frequency limits, bruxism, downgrades (e.g. composite fillings to amalgam fillings, onlays/inlays to fillings, porcelain on molar teeth crowns, etc.), and other frequency limits (e.g. exams, prophylaxis, fluoride, x-rays). Any estimated amount not expected to be covered by your insurance is due at the time of treatment. Please note that all insurance estimates are subject to final approval by your dental insurance plan, and therefore the amount due is subject to change after final review by your insurance company.

ADDITIONAL LAB FEES: In certain situations, additional lab fees may be necessary and are an additional cost for such procedures (e.g. zirconia crowns, veneers, porcelain margins, etc.). You will be advised of any additional lab costs prior to the start of treatment and are responsible for such fees.

RESIN-BASED COMPOSITE FILLINGS: Most dental insurance plans do not allow full benefits for composites (white fillings), especially when performed on posterior (back) teeth. The plan benefit will customarily pay for less expensive amalgam fillings, which are silver/mercury based. In an effort to provide our patients the highest level of modern dental care, we do not provide amalgam fillings, and only provide composites. The difference is usually \$50-75 per filling and the patient is responsible for paying for the difference.

Continue on to next page... 



Please initial each space:

Office Policy & Patient Consent/Releases



I authorize the dentists and staff at this dental office to provide any and all forms of treatment and medication that may be necessary or advisable in connection with my (or my dependent's) dental care. I further consent to the dentists and staff choosing and employing such methods and means as is deemed fit. I understand that prior to treatment, a full explanation of the procedure(s) involved will be given to me, and I agree to ask any questions that I may have, and to raise any issues, prior to the start of the treatment. Also, I understand that there are rare but real risks associated with local anesthesia such as permanent or temporary paresthesia. I understand those risks and will ask any questions that I may have prior to treatment, and consent to local anesthesia being administered to me as part of my dental treatment.

I authorize the dentists and staff to take photographs, study models, and/or radiographs of my face, jaws, and teeth. I understand that these photographs, study models, and/or radiographs will be used as a record of my care and treatment, and further authorize their use for educational or teaching purposes by this office and this office only.

In consideration of services rendered, I hereby transfer and assign to Dr. Jamie Park, right, title and interest in any payment due for services as provided in the policy or policies of dental insurance(s) held by me. I understand that I am legally responsible for all cost of treatment, regardless of any estimated insurance balance, and that my portion for covered procedures may differ from estimates provided by this dental office. I further agree and authorize the dental office to release any information requested by my insurance company(s) or its representatives. If the dentists are not direct providers for my dental insurance provider, I understand that filing a claim with my dental insurance may be done strictly as a courtesy to me, and that I still remain liable for the full amount of fees for services rendered.

I understand and agree that any and all past due balances over thirty (30) days will be subject to a finance charge of 1.5% per month (18% annually). I further agree that where collection activities are employed, whether via collection agencies or legal proceedings, in order to collect any delinquent amounts owed by me, I shall be responsible for all costs of collection, including but not limited to, court costs, interest, and attorney fees in the amount of 33 and 1/3% of the total principal and interest owing on my account, whether or not formal litigation is instituted.

In the event that my check is returned for NSF or another reason, I agree to pay a non-refundable fee of \$50. For any refund or amount issued back to my credit card account, I agree to pay a fee equal to 3% of the transaction being refunded.

I understand that pursuant to Virginia Code 32.1-45.1, any patient who exposes a health care provider (or employee) to bodily fluid in a manner which may transmit the Human Immunodeficiency Virus (HIV), Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis B and C testing, and disclosure of the results to the person exposed. Conversely, this deemed consent also applies to a health care provider (or employee) who exposes a patient to bodily fluid in same manner. In the case the above stated condition occurs, I agree to comply fully and immediately with the above referenced Code.

If necessary, I agree to cancel or reschedule any appointment at least two business days prior to my appointment time in order to avoid a \$50 non-refundable cancellation fee. I also agree that being substantially late for an appointment, or missing an appointment altogether, shall be deemed a cancellation and that the cancellation fee will apply.

Signature

I have read and understood this entire agreement before signing here below, and I have endorsed this agreement voluntarily, without duress, and of my own free will and choice. I certify that the information I have provided, especially regarding my medical history, is accurate and that I understand that incorrect or incompleated information being provided may be dangerous to my health. I also agree to abide by the office's policies, including its payment and financial policies. Furthermore, I have reviewed and accept the office's "Notice of Privacy Practices (HIPAA)" that is available both on the office's website as well as at the office upon request.

Name of Patient or Representative (please PRINT): _____

Signature of Patient (or Representative): _____

Date: _____

Records Release / Request

(for sending records to the Office of Jamie Park DDS & Assoc.)

To: _____
Doctor / Practice Name

Address: _____
Doctor / Practice Street Address

City ST ZIP Code

I hereby authorize the release of my records, including treatment plans or notes, and most recent x-rays (both bite-wings and panoramic), to the following office:

Office of Jamie Park DDS & Associates

10680 Main Street
Suite 150
Fairfax, VA 22030

Please prepare and...

mail to the office above

OR

hold for me to pick up

OR

FAX them to 703-665-0664

OR

E-mail them to: contact@jamieparkdds.com

SPECIAL NOTE REGARDING MY X-RAYS:

If my x-rays are maintained in electronic form, instead of providing them in printed form, please e-mail them in their **original / maximum** and **full-size**, in either "JPG" or Dentrix's "VNS" format, to: contact@jamieparkdds.com

Patient Printed Name: _____

Patient Date of Birth: _____

Patient Signature: _____

Date: _____

Patient Telephone: _____