DENTALCARE
BURKE

Bernard W Lynch, DMD, FAGD

Dental Care Burke 703.596.1555 9239 Old Keene Mill Road · Burke VA 22015

NEW PATIENT INFORMATION

Patient Name: _____ Date: _____

Please answer the following completely and thoroughly:

1. What specifically happened that prompted you to call Dr. Lynch?

2. What are your expectations for today's appointment?

3. If you have a dental problem, what is the one thing you hate most about your dental problem?

4. What would you like to hear during your consultation visit with Dr. Lynch?

5. When do you want to start your care?

6. What is the most important improvement you'd like to see once your dental treatment with Dr. Lynch is complete?

7. What do you feel is your main dental problem? What do you feel is wrong? How long have you suffered?

8. Rate how much your dental problem affects you in each of the following areas, 1 = no affect - 10 = affects me very much:

   Pain: _____ Embarrassment: ____ Eating difficulty: ____ Willingness to Smile: ____

9. Please list everything you've done to try to handle the problem that hasn't worked:

10. Why do you feel that right now is the time to fix your dental problems?

11. How are your dental problems affecting your everyday life?

12. Please tell us about any past dental experiences that were upsetting to you?

13. What Improvements would you make in the appearance of your teeth? And why?

14. So let's say we find something. Do you prefer to save your teeth?

15. Is there anything that would stand in your way of getting the proper dentistry you need? For example health, work, school, finances.

16. Do you have any questions for me?

MEDICAL HISTORY INFORMATION

Name _____ Date _____-_____-_____

Date of Last Dental Visit: _____-_____-_____ Reason for this Visit: _____

Have you ever had any of the following? Please check those that apply:

- ○ AIDS/HIV
- ○ Acid Reflux
- ○ Anemia
- ○ Arthritis/Rheumatism
- ○ Artificial Joints
- ○ Artificial Heart Valves
- ○ Asthma
- ○ Back or Neck Problems
- ○ Bleeding Problems
- ○ Cancer/Tumors
- ○ Chest Pain
- ○ Chemotherapy
- ○ Chronic Headaches
- ○ Diabetes Type I ___ Type II ___
- ○ Dizziness/Fainting
- ○ Epilepsy
- ○ Emphysema
- ○ Glaucoma
- ○ Hay fever
- ○ Head injuries
- ○ Heart disease
- ○ Heart murmur/MVP
- ○ Hepatitis A, B, C
- ○ High/Low Blood Pressure
- ○ Jaundice
- ○ Jaw Problems
- ○ Kidney Disease
- ○ Liver Disease
- ○ Leukemia
- ○ Mental Disorders
- ○ Neck Problems
- ○ Nervous Disorders
- ○ Oral Herpes
- ○ Pacemaker
- ○ **Pregnancy** Due Date:_____
- ○ Radiation Treatment
- ○ Respiratory Problems
- ○ Rheumatic Fever
- ○ Shingles
- ○ Sinus problems
- ○ Stomach Problems
- ○ Stroke/Heart Attack
- ○ Thyroid Problems
- ○ Tuberculosis (TB)
- ○ Ulcers
- ○ Sexually Transmitted Disease (STDs)

ALLERGIES

- ○ Codeine Allergy
- ○ Penicillin Allergy
- ○ Sulfa Allergy
- ○ Aspirin Allergy
- ○ Tetracycline Allergy
- ○ Latex Allergy
- ○ Environmental Allergies
- ○ Other Allergies: _____ _____
- ○ Other Conditions Not Listed: _____ _____

- Are you in general good health at this time? ☐ Yes ☐ No
  If yes, please rate from 1(best) -10 (worst):_____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:
  _____
- Do you use tobacco? ☐ Yes ☐ No
  How much? _____ How long? _____ Type? _____
- Have you ever had an allergic reaction to Novocaine anesthetic? ☐ Yes ☐ No
  If yes, any reactions or allergic symptoms, please explain:
  _____
- Do you have a history of Periodontal (gum) Disease? ☐ Yes ☐ No
- Have you been admitted to a hospital or needed emergency care during the past two years?
  ☐ Yes ☐ No
  If yes, please explain:
  _____
- Are you now under the care of a physician? ☐ Yes ☐ No
- Are you taking medication? ☐ Yes ☐ No
  If Yes, Please list ALL (Herbs, Vitamins, Aspirin)
  List: _____
- Name of Physician: _____ Phone: _____-_____-_____
- Please explain if you have any health problems that need further clarification? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _ _ _- _ _ - _ _ _ _ Birth Date: _ _- _ _ - _ _ DL#_____ Issuing State _____

Phone (Home): _____(Work): _____ Ext: _____ Cell Phone: _____

Email address: _____ May we contact you by email? ☐ Yes ☐ No

Address:_____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐ Brochure ☐ Dental Office ☐ Previous Practice ☐ Website ☐ Other_____ Name of person or office referring you to our practice:_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address:_____
Street City State Zip Code

Insurance Information
We will assist in your insurance processing

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____Social Security #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name and Address: _____
If you have dental insurance, we will help you receive the maximum benefits from your policy. As a courtesy to you, we will complete a claim form and send it to your insurance company. You can be reimbursed by your insurance company to your home or have the reimbursement received at the office for future treatment credit.

Consent for Services

Payment for dental treatment is due at the time service is rendered. In addition to cash and checks, we accept most major credit cards and Care Credit. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.
_____ Date: _____

Relationship to Patient: _____

Signature of patient, parent or guardian
_____ Date: _____

Relationship to Patient: _____

Signature of guarantor of payment/responsible party

DENTAL CARE BURKE
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11-01-05, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For Example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We are not affiliated with any insurance companies and do request payment at the time of service. Financial Arrangements can be discussed with our Business Team. A monthly service charge of 3% will be added to accounts 30 days past due.

Healthcare Operations: WE may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals,

evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, YOU may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: WE must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with the payment of your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or insist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to reject such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or the safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. WE may disclose to correctional institution or law enforcement official

having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, post cards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, there will be a charge of $55.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge you a cost-based fee for providing your health information in that format. If you prefer, we will provide a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances on which our business associates or we disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information, about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Dental Care Burke

Telephone: 703-596-1555 Fax: 703-543-0327

E-mail: info@dentalcareburke.com

Address: 9239 Old Keene Mill Road
Burke VA 22015

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this Office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual failed to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify)

  _____
  _____
  _____
  _____