5765-M Burke Centre Parkway,
Burke, V.A, 22015
703-459-9495

Patient Information

First Name _____ Last Name _____ Middle initial_____

Address _____

City, State,Zip_____

Home Phone _____ Cell Phone _____ Birth Date _____

Occupation _____ Email _____ Sex ____ M_/ F_____

SSN _____ Driver License _____

Whom may we thank for referring you? _____

Emergency Contact _____ Phone _____

May we text you to confirm your appointment? Yes/No

There is a $30.00 charge for broken appointments (no shows) and all cancellations made less than 24hours prior to appointment time. Monday appointments need to be cancelled on Saturday by noon to avoid being charged.

Primary Insurance

Policy Holder _____ Relation to Patient _____

Birthdate_____ SSN _____

Address (if different from patient's) _____

City, State, Zip _____Phone _____

Employer _____

Insurance Company _____

Member I.D. _____Group number_____

Other Dependents covered under this plan _____

Additional Insurance

Is the patient covered by additional insurance? ____Y/N_____

Policy Holder _____ Relation to Patient _____

Birthdate_____ SSN _____

Address (if different from patient's) _____

City, State, Zip _____Phone _____

Employer _____

Insurance Company _____

Member I.D. _____Group number_____

Other Dependents covered under this plan _____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____
(Name of Insurance Company)

and assign directly to Dr. Vivek Vij DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my healthcare information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or 1 year from the date signed below.

_____ _____

Signature of Patient/Parent/Guardian

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

-Payment by cash

-Payment by check

-Payment by credit card

Automatic monthly billing to your Visa or MasterCard

-Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the Visa and MasterCard Health Care Program which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

X _____

Print your name here and sign below

X_____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

BURKE PARKWAY DENTAL
5765-M BURKE CENTRE PARKWAY
BURKE, VA-22015

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of BURKE PARKWAY DENTAL'S *HIPAA Notice of Privacy Practices*.

I understand that BURKE PARKWAY DENTAL'S *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of BURKE PARKWAY DENTAL'S revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about BURKE PARKWAY DENTAL'S *HIPAA Notice of Privacy Practices*, I may contact SONAM, 5765-M BURKE CENTRE PARKWAY, BURKE, VA-22015

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that BURKE PARKWAY DENTAL will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding BURKE PARKWAY DENTAL'S privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask SONAM noted above, for assistance.

_____	_____
Patient Signature	Date
_____	_____
Signature of Personal Representative	Print Name of Personal Representative
	_____
	Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

BURKE PARKWAY DENTAL made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, BURKE PARKWAY DENTAL was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID

Time 11:42 AM | Burke Parkway Dental | Date 10/24/2016

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____