Top Dental

Patient Registration Form

Thank you for choosing our practice! We look forward to taking care of all your dental needs.
Please fill out this form in ink only and ask for assistance if you have any questions.

_____
Legal Name □ Male □ Female

SS#_____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered

_____
Home Address City State Zip

_____
Date of Birth Age Home Phone Cell Phone

Email Address_____

Name of Legal Guardian if Patient is Minor_____

Occupation _____ Employer Name_____

Business Address_____

Business Phone _____

Emergency Contact
_____ Phone _____

What is the best way to contact you? □ Home □ Cell □ Email □ Work □ Mail

Referred By _____

Have you ever been to our office before? □ YES □ NO

Top Dental
10529 Crestwood Dr Suite 103 Manassas, VA 20109
3025 Hamaker Ct suite 400. Fairfax VA 22031
(703) 393-9393 (703) 393-9394
info@topdentalpractice.com www.topdentalpractice.com

How did you hear about us? □ El Tiempo Latino □ El Imparcial □ Washington Hispanic
□ Radio □ Dentist □ Friend □ Other _____

Primary Dental Insurance Information

Subscriber's Name_____

Relationship_____

Birthdate_____ SS#_____

Insurance Company_____

ID#_____

Group #_____

Insurance Phone# _____

Insurance Address _____

Secondary Dental Insurance Information

Do you have secondary dental insurance? □ YES □ NO

Subscriber's Name _____

Relationship _____

Birth date _____ SS# _____

Insurance Company _____

ID# _____

Group # _____

Insurance Phone# _____

Insurance Address _____

DENTAL HISTORY

What is the most important reason for your dental visit today? _____

If you could improve your current dental condition what would it be? _____

Please Share Some Dates:

Your Last Cleaning _____

Your Last set of X-rays _____

Your Last Oral Cancer Screening _____

Your Last Dental Exam _____

On a Scale of 1-10, with 10 being the highest rating:

How important is your dental health?

1 2 3 4 5 6 7 8 9 10

Where would you rate current dental health?

1 2 3 4 5 6 7 8 9 10

Do any of the following problems apply to you?

Sensitivity (Hot/Cold/Sweets) □ YES □ NO

Headaches, Earaches, Neck pain □ YES □ NO

Teeth or Fillings breaking □ YES □ NO

Bleeding, Swollen or Irritated gums □ YES □ NO

Food Collection between Teeth □ YES □ NO

Loose, Tipped or Shifted teeth □ YES □ NO

Bad Breath □ YES □ NO

Do you grind your teeth? □ YES □ NO

Do you wear a dental splint for this condition? □ YES □ NO

Have you ever been treated for Periodontal Gum disease? □ YES □ NO

Do you have/had any of the following? Dentures Partials Braces Periodontal (gum) Treatment

Is there any possibility you may be pregnant? □ YES □ NO
Are you trying to get pregnant? □ YES □ NO

Do you have a family dentist? _____ Last visit_____

MEDICAL HISTORY

Physician's Name_____ Phone_____ Last Exam_____

For the following please circle yes or no. **Your answers are for our records only and will be confidential**. Please note that during your initial visit you will be asked some questions about your responses. Our staff may ask additional questions regarding your health.

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

Are you under a physician's care now? □ YES □ NO

If yes, please explain _____

Have you ever been hospitalized or had a major operation? □ YES □ NO

If yes, please explain _____

Have you ever had a serious head or neck injury? □ YES □ NO

If yes, please explain _____

Do you take, or have you taken, Phen-Fen or Redux? □ YES □ NO

Are you currently taking or have you ever taken any bisphosphonates or medications for osteoporosis? (For Example: Actonel, Boniva, Fosamax, Skelid, etc.) □ YES □ NO

Please list name of current or past prescribed bisphosphonate drug(s): _____

Are you on a special diet? □ YES □ NO

Do you use tobacco? □ YES □ NO

Do you use controlled substances? □ YES □ NO

Do you consume alcohol? □ YES □ NO If yes, approximately how many per week? _____

Women: Are you pregnant? □ YES □ NO

Are you a nursing mother? □ YES □ NO Are you taking birth control? □ YES □ NO

Do you Pre-Medicate before dental visits?	NO	YES	Tagamet (Cimetidine) or Prilosec (Omeprazole)	NO	YES
Antacids?	NO	YES	Cardizem (Diltiazem) or Calan, Isoptin (Verapamil)	NO	YES
Diantin or Tegretol	NO	YES	Serzone (Nefazodone)	NO	YES
Barbiturates (any)	NO	YES	Diflucan (Fluconazole) or Sporonox (Itraconazole)	NO	YES
St. John's Wort or Kava-Kava	NO	YES	Biaxin (Clarithromycin)	NO	YES
Bloodthinners (Coumadin, Warfarin)	NO	YES	Levoxl, Synthroid	NO	YES
Fen-Phen, Redux, Pondimin	NO	YES	Do you consume Grapefruits, juice, or extract	NO	YES

Please list any other medications or dietary/herbal supplements you are currently taking and for what purpose:

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

Do you use any mood altering drugs other than those previously listed? □ YES □ NO

Are you allergic or have reactions to:

Local Anesthetics	NO	YES	Codeine, Valium or other sedatives	NO	YES
Penicillin or other antibiotics	NO	YES	Latex	NO	YES
Aspirin, Ibuprofen, Tylenol	NO	YES	Metals	NO	YES
Other (Please specify)					

Dental Treatment

Please initial permission for us to do these items during your consultation.

□ Ready to start today Panoramic x-ray _____ **initials**

□ Gathering information _____ **initials**

***** There may be a fee for copies of the x-ray if you wish to have them.

Signature of Patient/Guardian _____ Date _____

Certification and Assignment

To the best of my knowledge the above information is complete and correct. I understand that the above information is necessary to provide me with dental care in a safe and efficient manner, and that **providing incorrect information can be dangerous to my (or patient's) health**. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health. Should further information be needed you have my permission to ask the respective health care provider or agency, who may release such information to you. I certify that I and my dependent(s), have insurance coverage with _____and assign directly to **TopDental Fairfax PC** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance claims. The above-named doctor and facility may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I hereby authorize **TopDental Fairfax PC** to take study models, X-rays, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize **TopDental Fairfax PC** to perform any and all forms of treatment, medication, and therapy that may be indicated, I also understand that the use of anesthetic agents embodies a certain risk.

Financial Policy

By signing below you are stating you understand the following: Payment is due at the time services are rendered. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Our office also offers outside financing upon request and approval please ask for further details. I authorize this office to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options. As a courtesy to our insured patients, we will gladly file your dental claims for services rendered. Please understand that we are only given an estimate for your dental care therefore we can only pass the estimate on to you, the patient. After your insurance pays their portion there may still be an amount due. This amount will be your responsibility and will be sent to you in the form of a statement. Please understand that we will do our best to get your insurance to pay for all work performed by our office, however most insurance plans only pay for a portion of dental services. Please understand that if after 60 days there has been no payment made it is your responsibility to follow up with your insurance and retain payment.

Signature _____ Date _____

Patient, Parent, Guardian, or Personal Representative

Doctor's Signature _____ Date _____

Name _____ Age _____ Date_____

HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights have been given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize **TopDental Fairfax PC** to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. insurance company)
- Day-to-day healthcare operations of the practice (e.g. email/ text reminders/ confirmations of appointments via online services)

I have also been informed of, and given the right to review a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that **TopDental Fairfax PC** reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____

Patient Name Printed _____

Signature _____

Relationship to patient _____