Lansdowne Family & Cosmetic Dentistry

WELCOME

Please take a few minutes to complete the following confidential information.
If you have any questions we'll be glad to help you.

Patient Information

Date _____ Social Security # _____ Birth Date _____
Last Name _____ First Name _____ Home Phone _____
Address _____
City _____ State _____ Zip _____
☐ Male ☐ Female Age _____ ☐ Single ☐ Married ☐ Divorce ☐ Widowed
E-Mail Address _____ Cell Phone _____
Where can you be reached during the day? ____ Home ____ Work ____ Cell ____ E-mail
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Whom may we thank for referring you? _____
Person to contact in case of an emergency _____ Phone _____
Closest relative not living with you _____ Phone _____
Address _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company

And assign directly to Drs. Ellington and Hulbert all 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 for myself and/or minor children. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date _____ Signature _____

Primary Dental Insurance

Employee (Subscriber) _____
Insurance Company _____ Group # _____
Employer _____
Business Address _____ Phone _____
Occupation _____
Employee date of birth _____ Social Security # _____ Date employed _____

PATIENT NAME:_____ **DENTAL HISTORY**

All information is completely confidential.

What is the reason for you visit today? _____

_____

Date of last dental visit: _____ Last dental cleaning: _____Last full mouth x-rays: _____
Previous Dentist's Name: _____
Address: _____
Telephone: _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
What other dental aids do you use? (Waterpik, tooth pick, ect.) _____

Do you have dental problems now? YES NO
If yes please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	YES	NO
Sweets?	YES	NO
Biting or chewing?	YES	NO
Do you frequently get cold sores, blisters or any other lesions?	YES	NO
Do your gums bleed or hurt?	YES	NO
Have your parents experienced gum disease or tooth loss?	YES	NO
Have you noticed any loose teeth?	YES	NO
Have you noticed any change in your bite?	YES	NO
Does food tend to become caught between your teeth?	YES	NO

If so, where?_____

Do you:

Clench or grind your teeth while awake or sleeping?	YES	NO
Bite your lips or cheek regularly?	YES	NO
Hold foreign objects with your teeth (pencils, pipe, pins, nails)?	YES	NO
Mouth breathe while awake or asleep?	YES	NO
Have tired jaw?	YES	NO
Smoke or chew tobacco?	YES	NO

If yes, how many packs a day? _____

Have you ever had:

Orthodontic treatments? (braces)	YES	NO
Oral surgery?	YES	NO
Periodontal treatment? (treatment for gums)	YES	NO
A bite plate or mouth guard?	YES	NO
A serious injury to the mouth or head?	YES	NO

If so, please describe, including cause:_____

_____

Have you experienced:

Clicking or popping of the jaw?	YES	NO
Pain? (joint, ear, side of face)	YES	NO
Difficulty in opening or closing your mouth?	YES	NO
Difficulty in chewing on either side?	YES	NO
Are you satisfied with your teeth's appearance?	YES	NO

If not, what would you like to change?_____

_____

Would you like to keep all your teeth all your life?	YES	NO
Do you feel nervous about having dental treatments?	YES	NO

If so, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience?	YES	NO

If so, please describe: _____

_____

Is there anything else about having dental treatment that you would like for us to know? YES NO
If so, please describe: _____

_____

PATIENT NAME: _____ **MEDICAL HISTORY**

1. Have you been under the care of a medical doctor during the past two years? YES NO
   If yes, for what? _____
   Physician's Name: _____ Phone: _____
   Address: _____ City: _____ State: _____
2. Have you taken any prescription, herbal, or over the counter medications in the past two years? YES NO
   If yes, please list name and dosage:
   _____
   _____
   _____
3. Are you aware of having an allergic (or adverse) reaction to any medication or substance? YES NO
   If yes, please list: _____
4. Have you been a patient in the hospital during the past five years? YES NO

Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item.

Heart (Surgery, Disease, Attack)	YES	NO	Ulcers	YES	NO	Hepatitis A or B	YES	NO
Chest Pain	YES	NO	Diabetes	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Thyroid Problems	YES	NO	AIDS	YES	NO
Heart Murmur	YES	NO	Glaucoma	YES	NO	HIV Positive	YES	NO
High Blood Pressure	YES	NO	Contact Lenses	YES	NO	Cold Sores/Fever	YES	NO
Mitral Valve Prolapsed	YES	NO	Emphysema	YES	NO	Blisters	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Blood Transfusion	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Hemophilia	YES	NO
Rheumatic Fever	YES	NO	Asthma	YES	NO	Sickle Cell Disease	YES	NO
Arthritis/Rheumatism	YES	NO	Hay Fever	YES	NO	Bruise Easily	YES	NO
Cortisone Medicine	YES	NO	Latex Sensitivity	YES	NO	Liver Disease	YES	NO
Swollen Ankles	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Diet (Special/Restricted)	YES	NO	Sinus Trouble	YES	NO	Neurological Disorders	YES	NO
Artificial Joints (hip, knees)	YES	NO	Radiation Therapy	YES	NO	Epilepsy or Seizures	YES	NO
Kidney Trouble	YES	NO	Chemotherapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Stroke	YES	NO	Tumors	YES	NO	Nervous/Anxious	YES	NO
						Psychiatric/ Psychological Care	YES	NO

5. Do you take, or have you taken diet drug Phen-Fen or Redux?* YES NO
   *If yes to the above, did you have a medical exam for heart issues? YES NO
6. Are you taking any medication for the treatment of osteoporosis or bone disease? YES NO
7. Do you use more than two pillows to sleep? YES NO
8. Have you lost or gained more than 10 pounds in the past year? YES NO
9. Do you have or have you had any disease, condition, or problem not listed? YES NO
   If yes, please list: _____
10. Women: Pregnant? Yes___ # months___ No___ Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. 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 will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of **Lansdowne Family & Cosmetic Dentistry**. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities an duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Lansdowne Family and Cosmetic Dentistry reserve the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected heath care information to the persons indicated below.		
ANY MEMBER OF MY IMMEDIATE FAMILY	☐ YES	☐ NO
SPOUSE ONLY	☐ YES	☐ NO
OTHER (Please Specify)	☐ YES	☐ NO

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement Not Obtains		
Provided Prior To Treatment?	☐ Yes ☐ No	
Date Provided:		
Reason For Denial	Needed more time to review Statement of Privacy Practices.	
	Wanted to consult with another person before signing.	
	Unable to sign	
	Reason not given	
	Other (Explain) _____	

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and the state of Virginia. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone - even family members - without your written consent. You, of course, may give written authorization for us to disclose you information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Your Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Numbers, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to full extent of the law.

Disclosure Of Your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for use other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have questions concerning your privacy rights and the protection of your personal health information.