Expressions
DENTAL CARE

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ Social Security # : _____

_____ Home Phone # : _____

_____ Cell Phone # : _____

Age: ___ Sex: ___ Marital Status:_____ Work Phone # : _____

E-mail: _____ (will only be used for office communications)

Whom may we thank for referring you? _____

If you were referred to our office by a current patient outside of your immediate family, our CARE TO SHARE program allows you both to earn $25 credit or gift card for both of you!

PRIMARY INSURANCE INFORMATION

Policy Holder: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____

_____ Social Security #: _____

Employer: _____ Phone #: _____

Insurance Co: _____ Phone #: _____

Address: _____ Member ID #: _____

_____ Group #: _____

EMERGENCY CONTACT / RESPONSIBLE PARTY INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Home Phone #: _____

_____ Cell Phone #: _____

Relationship to Patient: _____ Work Phone #: _____

E-mail: _____ (will only be used for office communications)

Is this person currently a patient in our office? □Yes □No

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PATIENT MEDICAL HISTORY

Primary Care Physician: _____ Phone #: _____ Date of Last Exam:_____

Have you ever been told you have one of the following?

____ Heart Disease	____ Anemia	____ Asthma	____ Heart Murmur	____Congenital Heart Defect
____ Bleed Easily	____ Swollen Ankles	____ Heart Attack	____ Shortness of Breath	____Joint Replacement/Implant
____ Fainting / Seizures	____ AIDS / HIV	____ Arthritis	____ Chest pain - Angina	____Recent Weight Loss
____ Hay Fever / Allergies	____ Emphysema	____ Cancer	____ Epilepsy / Convulsions	____Psychiatric Treatment
____ Kidney Disease	____ Rheumatic Fever	____ Diabetes	____ High Blood Pressure	____Radiation Therapy
____ Liver Disease	____ Stomach Ulcer	____ Stroke	____ Low Blood Pressure	____Mitral Valve Prolapse
____ Hepatitis	____ Thyroid Disease	____ Glaucoma	____ Leukemia	____Sexually Transmitted Disease
____ Jaundice	____ Other: _____			

Are you sensitive (allergic) to any drugs or anesthetics?
☐Penicillin ☐Aspirin ☐Codeine ☐Sulfa ☐Novocaine
☐Other:_____

Yes **No**

☐ ☐ Are you under any medical treatment now? If yes, please explain:_____

☐ ☐ Have you ever had any other serious illness not listed above? If yes, please explain:_____

☐ ☐ Are you currently taking any medications? If yes, please explain:_____

☐ ☐ Have you ever had a bad reaction to a local anesthetic or penicillin? If yes, please explain:_____

☐ ☐ Do you use tobacco? If yes, please explain:_____

☐ ☐ Do you use alcohol, cocaine, or other drugs? If yes, please explain:_____

Women: Are you : Pregnant ☐Yes ☐No Nursing? ☐Yes ☐No Taking Birth Control Pills ☐Yes ☐No

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I certify that I have read and understand the above information and have answered to the best of my knowledge. I understand that this information is necessary to provide me with dental care in a safe and effective manner. I understand that providing incorrect information can be dangerous to my health. I understand I am responsible for all cost of dental treatment. I hereby authorize this office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

- Pursuant to Virginia Law 32.1-45.1 - Any patient who exposes a health care provider or his employee/agent to body 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. This deemed consent also applies to a health care provider who exposes a patient to body fluid in the above stated manner.

_____ _____
(Please Print) Name of Patient Today's Date

_____ _____
Signature of Patient/Guardian Dr. John Han, DMD

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FINANCIAL POLICY

Thank you for choosing Expressions Dental Care as your dental care provider. Our office is committed to providing you with the highest quality dental care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. We do provide several payment options to accommodate our patient's needs. ***Please discuss your options with our staff to find the solution that is best for you.***

- Charges for services are due and payable the day of the appointment; Patient Copay
- We will assist with filing insurance; however, the patient, parent, or guardian is directly responsible for payment in full of any and all fees not paid for by the insurance company. There are no exceptions. When treatment co-pays are quoted by the office, these are estimates only, your actual insurance coverage may be less or more. There are no guarantees of payment by insurance when services are rendered.
- Personal checks that are returned due to insufficient funds are subject to a $30.00 service fee
- Appointment cancellations with less than 48 (business) hours notice are subject to a fee of $60.00 for each appointment scheduled for less than 90 minutes and $200.00 fee for appointments scheduled for 90 minutes or longer that are missed.
- ***Appointments 90 minutes or longer: We require the patient portion to reserve the time***
- All unpaid accounts over 60 days will be considered past due. Such accounts are subject to 18% APR or 1.5% monthly finance charges. Past due accounts may be referred to an authorized collection agency. Accounts sent to a collection agency will be assessed a $30.00 collection fee or 33 ⅓% collection charge on the unpaid balance, whichever is greater. The patient, parent, or guardian will also be liable for any applicable attorney fees and court costs. Accounts that have been referred to an outside collection agency will be placed on a CASH ONLY basis for any future treatment.
- We are required by the State of Virginia to keep patient records for three years past the final date of treatment. Records of patients that have not been to this office in over three years may be purged. If you are moving or leaving the practice for any reason, you may want to request a copy of your records. There may be a minimal charge to copy your x-rays and records.
- Payment plans are available only for orthodontic treatment, and must be made PRIOR to starting treatment.
- Amalgams (silver fillings) are no longer used at this office. Most insurance companies do not pay full benefits due to exclusions in individual policies for composite (tooth colored) fillings. The patient, parent, or guardian is liable for all additional costs.

I have read and understand the Financial Policy of Expressions Dental Care. I understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. I authorize and request my insurance company to pay directly to Expressions Dental Care any insurance benefits otherwise payable to me. I Understand that my dental insurance carrier may pay less than the actual bill for services and Expressions Dental Care completes and files my insurance claims as a courtesy. I understand that I am responsible for any unpaid or denied claims.
Thank you for understanding that as your dental care provider, our relationship is with you and not your insurance company. I agree to be responsible for all dental services and materials not paid by my dental insurance for me or my dependents. I authorize release of any information relating to any insurance claims to the relevant insurance company. I authorize payment of dental insurance benefits to Expressions Dental Care, unless payable to me directly per the insurance plan.

_____ _____
Please Print Name of Patient, Guardian, or Responsible Party Date

_____
Signature of Patient, Guardian, or Responsible Party

Expressions
DENTAL CARE

SMILE ASSESSMENT FORM

Please consider each statement carefully and circle one or more that applies to you:
The doctor and members of the dental team will discuss your responses with you in confidence.

1. I am concerned about the appearance of my teeth or my smile.
2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth.
3. I am concerned about the position or angle of one or more than one of my teeth.
4. I am concerned about the shape of one or more than one of my teeth.
5. In social situations, I am sometimes embarrassed by my teeth or my smile.
6. There are some things about my upper front teeth that I would like to change.
7. There are some things about my lower front teeth that I would like to change.
8. I have old fillings or previous dental treatment that is no longer satisfactory to me.
9. I am missing one or more of my teeth.
10. I am interested in learning more about esthetic dentistry.

PATIENT DENTAL HISTORY

Previous Dentist: _____ Phone #:_____ Date of Last Exam: _____

Location: _____ Date of last cleaning: _____

What is the reason for your visit today?

_____

Do you have any pain or discomfort now? □Yes □No If so, please explain: _____
How many times per day do you brush your teeth? _____
Do you floss? □Yes □No If so, how often?_____
Are your teeth sensitive to hot or cold liquids? □Yes □No Sweet/Sour liquids/foods? □Yes □No
Have you ever worn braces? □Yes □No Do you wear Dentures? □Yes □No
Have you ever had any trauma to your face or mouth? □Yes □No
Do you clench/grind your teeth? □Yes □No
Have you ever had prolonged bleeding after extractions? □Yes □No
Do you bite your lips/cheeks frequently? □Yes □No
Do you have any sores or lumps in or around your mouth? □Yes □No Do you like your smile? □Yes □No

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly.
2. Obtain payment from third-party payers for my health care services.
3. Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of dental providers notice of privacy Practices Containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand That my dental provider has the right change the Notice of Privacy Practice and that I may contact this office at the address above to obtain a current copy of the notice of Privacy Practices.

I Understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

1. Pursuant to Virginia Law 32.1 1-45.1- any patient who exposes a health care provider or his employee/agent to body 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 provider who exposes a patient to body fluid in the above stated manner.

Print Patient Name:_____Date:_____

Signature:_____

Relationship to Patient:_____

Office USE ONLY-Patient Name:_____ Date_____

Tooth	Previous Tx	PC Facial DBM	PC Lingual MBD	Tx Suggested
1		1	1	1
2		2	2	2
3		3	3	3
4		4	4	4
5		5	5	5
6		6	6	6
7		7	7	7
8		8	8	8
9		9	9	9
10		10	10	10
11		11	11	11
12		12	12	12
13		13	13	13
14		14	14	14
15		15	15	15
16		16	16	16
17		17	17	17
18		18	18	18
19		19	19	19
20		20	20	20
21		21	21	21
22		22	22	22
23		23	23	23
24		24	24	24
25		25	25	25
26		26	26	26
27		27	27	27
28		28	28	28
29		29	29	29
30		30	30	30
31		31	31	31
32		32	32	32

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