Patient Registration

WestLake Dental Care

PATIENT LAST NAME:_____ FIRST:_____ INITIAL:_____

How do you wish to be addressed?_____ Date of Birth _____

Address_____ City_____ State_____ Zip _____

Telephone (Mobile)_____ (Work)_____ (Home) _____

Email_____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name_____	Subscriber Name_____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PART Y *(If minor)*

Last Name:_____ First:_____ Initial:____

Address *(If different)*_____ Date of Birth _____

City_____ State_____ Zip _____

Telephone (Home)_____ (Work)_____ (Mobile) _____

Email _____

EMERGENCY CONTACT

Last Name:_____ First:_____ Initial:_____

Telephone (☐Mobile ☐Work ☐Home) _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying STOP via text to 98269. *Go to www.greatexpressions.com for more information.*

I attest to the accuracy of the information on this page.

Signature_____ Date _____

(Responsible Party, if under 18)

WestLake Dental Care

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME:_____ PATIENT FIRST NAME: _____

DENTAL HISTORY

Reason for today's visit_____ Date of last dental visit _____

Former dentist_____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No		Yes	No
Bad breath	☐	☐	Head, neck, jaw pain, or aches	☐	☐
Blisters on lips or mouth	☐	☐	Lip or cheek biting	☐	☐
Burning sensation on tongue	☐	☐	Loose teeth or broken fillings	☐	☐
Chew on one side of mouth	☐	☐	Mouth breathing	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐	Orthodontic treatment	☐	☐
Smokeless tobacco	☐	☐	Nitrous Oxide	☐	☐
Dry mouth	☐	☐	Periodontal treatment	☐	☐
Food collection between teeth	☐	☐	Sensitivity to pressure or irritants	☐	☐
Clench or grind teeth	☐	☐	(cold, heat, sweets)		
Growths or sore spots in your mouth	☐	☐	How often do you floss? _____		
Gums swollen, tender or bleeding	☐	☐	How often do you brush? _____		

Have you ever had an allergic reaction to Novocain, local, or general anesthetics? ☐Yes ☐No

If Yes, please explain _____

_____

_____

Have you ever had trouble from previous dental care?

☐Yes ☐No If Yes, please explain _____

_____

_____

MEDICAL HISTORY

Physician's name_____ Date of last visit: _____ Blood Pressure:_____

Have you had any serious illnesses or operations Yes No If yes, please describe: _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

Women Only: Are you pregnant? Yes No Due date: _____

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	☐	☐	Headaches	☐	☐	Slow healing wounds	☐	☐
Anemia	☐	☐	Heart murmur	☐	☐	Stroke	☐	☐
Arthritis, Rheumatism	☐	☐	Heart problems	☐	☐	Swelling of feet or ankles	☐	☐
Artificial heart valves	☐	☐	Hepatitis type_____	☐	☐	Thyroid problems	☐	☐
Artificial joints	☐	☐	Herpes	☐	☐	Tonsilitis	☐	☐
Asthma	☐	☐	High blood pressure	☐	☐	Tuberculosis	☐	☐
Required Hospitalization	☐	☐	Any immune deficiency	☐	☐	Tumor or growth on head/neck	☐	☐
Have you used steroids	☐	☐	Jaundice	☐	☐	Ulcer	☐	☐
Date of last episode_____	☐	☐	Kidney disease	☐	☐	Venereal disease	☐	☐
Bleeding abnormally with operations or surgery	☐	☐	Low blood pressure	☐	☐	Weight loss, unexplained	☐	☐
Blood disease, clotting disorders	☐	☐	Mitral valve prolapse	☐	☐	Do you wear contact lenses?	☐	☐
Cancer	☐	☐	Osteoporosis	☐	☐	Do you consume alcoholic beverages?	☐	☐
Chemical dependency	☐	☐	Osteopenia	☐	☐	Are you currently under the care of a Physician?	☐	☐
Chemotherapy	☐	☐	Pacemaker	☐	☐	Are you allergic/sensitive to Latex?	☐	☐
Circulatory problems	☐	☐	Radiation treatments	☐	☐	Allergic to Penicillin, Aspirin, or other drugs?		
Cortisone treatments	☐	☐	Respiratory disease	☐	☐	*If Yes, please specify* _____		
Cough, persistent or bloody	☐	☐	Rheumatic fever	☐	☐	_____		
Diabetes	☐	☐	Scarlet fever	☐	☐	_____		
Emphysema	☐	☐	Shortness of breath	☐	☐	List any medications that you are taking:		
Epilepsy	☐	☐	Sinus trouble	☐	☐	_____		
Fainting	☐	☐	Sickle cell anemia	☐	☐	_____		
Glaucoma			Skin rash			_____		

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature_____ Date_____

Reviewed by:_____ Date _____

DENTAL & MEDICAL HEALTH HISTORY

MEDICAL HEALTH HISTORY – UPDATE AND EXCEPTIONS

I have read my medical history and confirm that it adequately states past and present conditions

DATE	EXCEPTIONS	NONE	PATIENT INITIALS	REVIEWED BY

Patient Registration

WestLake Dental Care

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Compliance Officer:
Telephone:
Address:

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: 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:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) _____

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.

PRIVACY PRACTICES RECEIPT / CONSENT FORM

SECTION E: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION F: PATIENT/RELATIVE HIPAA CONSENT

I,_____, understand that by signing this Consent form, I am giving my consent to_____to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name:_____

Relationship: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance Officer listed on Section B.

_____ _____

Patient's Signature (Legal Guardian, if Patient is a minor) Date:

SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request the office to restrict the disclosure of my PHI to those specified below:

Name: _____

Name: _____

Signature: _____ Date: _____

If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

WestLake Dental Care

Tarek Badawy DDS, FAGD
46175 Westlake Dr. Ste 130
Sterling, VA 20165
(Office) 703-444-5108 (Text) 703-420-3327

Thank you for choosing our office as your dental health provider. We are committed to providing you with the highest quality dental care so that you may fully attain optimum oral health. A clear, mutual understanding of our policies helps keep our office running smoothly and efficiently, and is part of building a successful and healthy Doctor/Patient relationship. Please read our policies below and sign to ensure a mutual understanding.

Financial Policies

(Initial)_____**If you do not have Dental Insurance,** please speak with our billing representative. We will help set up a payment plan that best suits your financial situation. We also offer **In-House Dental Plans** that will cover quality, regular cleaning for the year.

(Initial)_____**Payment of estimated patient portion is required before any treatment appointment is scheduled.** This ensures that your appointment time will be reserved for your care. Failure to make a payment before or at treatment visit could result in a late payment fee, a 1.5% interest charge, for which you are responsible. Parents/Guardians are responsible for full payment for minors/unaccompanied minors.

(Initial)_____**At least a 50% down payment is required** for procedures including Crowns, Bridges, Dentures, Partial Dentures, Implants, Night Guards, or anything needed to be sent out to a dental laboratory to be fabricated. The remaining balance will be due at time of visit. Payments plans are available to pay balance.

(Initial)_____Notify us as soon as possible for any credit card, insurance, or address changes. If your account becomes **inactive** (meaning you have not made a payment for more than **30 days**), your account will be charged at a **1.5% interest rate** for every 30 days that your account is not paid.

(Initial)_____**Delinquent accounts will be assigned to a credit reporting collection agency**. The patient agrees to pay legal interest on the indebtedness, together with such collection costs, and reasonable attorney fees as may be required to effect collection of this account.

Dental Insurance Policies

(Initial)_____**As a courtesy to all of our insured patients,** we will file your insurance claim forms. Your claim will be filed immediately and benefits are expected to be paid within 30 days. The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your insurance within 45 days, the unpaid portion will automatically become "self-pay". You are responsible for any amounts your insurance company chooses not to pay.

(Initial)_____Your dental insurance is a contract between you, your employer, and your insurance company. We are not a party in that contract. **It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy.**

(Initial)_____Your treatment plan is individually tailored for you needs, not based on your dental insurance benefits. **Not all services are covered benefits in all contracts.**

Continue to backside

Appointment Cancellation/No Show Policies

Cancellation

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment on time, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly "full" appointment book. We allocate a certain amount of time on our schedule for each patient's individual care. If you fail to cancel your appointment without 24 hours notice, we reserve the right to charge you a cancellation fee.

(Initial) _____If an appointment is not cancelled at least **24 hours** in advance, you will be charged a **$65 fee** that will **not** be covered by your insurance company.

Late Scheduled Appointments

(Initial) _____If a patient is **15 minutes** past their scheduled time, we will have to reschedule the appointment. Please give us a call to let us know that you will be running late.

No Show

(Initial) _____There is a **$65 fee** that will be charged for a patient who does not show up to their appointment without notice. This fee must be paid before booking another appointment.

Our front office attempts to contact all patients **2-3 days before their appointment**. Unfortunately, missed or failed appointments contribute to inefficient scheduling and lost time. If there are any changes in address or phone number that may complicate contact with you, please inform our front office as soon as possible. We are not responsible for missed appointments due to the inability to reach you. Please understand that these policies are meant to keep our practice running smoothly and efficiently.

I understand and accept the policies listed and have had any and all questions answered to my satisfaction. I agree to pay for all treatment in a timely fashion as described so as to avoid any additional fees.

I hereby authorize my insurance benefits to be paid directly to Westlake Dental Care. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original.

Patient Signature:_____ Date:_____