Patient Information

Patient Name:_____ **Date:**_____
Last First MI (Preferred Name)

Sex: ☐ Male ☐ Female **Family Status:** ☐ Single ☐ Married ☐ Widowed ☐ Other_____

Social Security #:_____ **Birth Date:**_____

Phone (Home):_____ **(Work):** _____ **Ext:** _____ **(Cell):**_____

Email: _____@_____

Address:_____
Street Apartment #

_____
City State Zip Code

Reason for this visit: _____ Who is your General Dentist: _____

Please check those that apply: (MAKE SURE YOU MARK EITHER YES OR NO, DO NOT LEAVE ANY BLANK)

YES	NO		YES	NO		YES	NO	
☐	☐	Take Aspirin	☐	☐	Fainting	☐	☐	Pacemaker
☐	☐	AIDS/ HIV	☐	☐	Glaucoma	☐	☐	Pregnancy
☐	☐	Arthritis	☐	☐	Growths	☐	☐	Radiation Treatment
☐	☐	Artificial Joints	☐	☐	Gout	☐	☐	Respiratory Problems
☐	☐	Asthma (have spray?)	☐	☐	Heart Disease	☐	☐	Rheumatic Fever
☐	☐	Blood Diseases	☐	☐	Heart Murmur	☐	☐	STD
☐	☐	Bone Medication:	☐	☐	Hepatitis A, B, C	☐	☐	Sinus Problems
Aredia, Boniva,Fosamax,zometa			☐	☐	High Blood Pressure	☐	☐	Stomach Problems
Alendronate, bisphosphonates			☐	☐	Hyper/Hypo Thyroidism	☐	☐	Steroid usage
☐	☐	Bleeding problems	☐	☐	Jaundice	☐	☐	Stroke
☐	☐	Cancer History	☐	☐	Kidney Disease	☐	☐	Tobacco /smoking
☐	☐	Chemical Dependency	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	Mental Disorders	☐	☐	Tumors
☐	☐	Dizziness	☐	☐	Nervous Disorders	☐	☐	Ulcers
☐	☐	Epilepsy	☐	☐	Osteopenia/prosis			
☐	☐	Excessive Bleeding	☐	☐	Organ transplant			

Any allergies:
☐ **YES** ☐ **NO**

Please list any allergies or medications:

DO YOU PRE-MEDICATE FOR DENTAL APPOINTMENTS? ☐ **YES** ☐ **NO** **FOR HEART REASONS or ARTIFICIAL JOINTS?** _____
IF YES, WHAT MEDICATIONS Amoxicillin/ clindamycin/ Keflex/other? _____

PLEASE LIST ALL PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS:_____
_____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- **Name of Physician:** _____ **Phone:** _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date:** _____
Signature of patient, parent or guardian

Responsible Party Information if the responsible party or insurer is another person (Example: parents, spouse, etc.)

Name _____ **Relationship:** _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ **(Work):** _____ **Ext:** _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment/Insurance Information

The following is for: **Insured/Responsible Party**

Employer Name: _____ **Occupation:** _____

Insurance Company :_____Group#_____ Policy ID#_____

Insurance Address:_____City:_____State:_____Zip:_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend, or relative: _____

☐ Dental Office ☐ Washingtonian/other magazines ☐ Dental Society ☐ Internet ☐ other: _____

Name of person or office referring you to our practice: _____

Consent for Services/Office Policy

I hereby consent to services to be performed by Dr. Christopher, Dr. Favagehi and their staff.
I understand Dr. Christopher & Dr. Favagehi are Periodontists (Specialists) and are licensed to practice dentistry in Virginia.
Radiographs, photographs and study models maybe produced as a diagnostic aid or document my condition. My privacy will be respected.
I understand dental treatment may at times cause adverse effects such as sensitivity, and in rare situations, it may result in damage to teeth/restorations and/or other injury.

I understand that I am fully responsible for payment for services to be rendered at the time the service is initiated, unless agreed otherwise. Any other financial arrangement, such as insurance or 3rd party payer arrangements must be made in advance.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, I understand that I am responsible for payments, and I shall not seek services on the assumption that charges will be paid by an insurance company. I understand that insurance companies may or may not reimburse for services provided by Drs. Christopher & Favagehi.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.
I further agree in the event of non-payment, to bear the cost of collections and/or court cost and reasonable legal fees should be required.

I grant my permission to Drs. Christopher & Favagehi and their staff, to contact me by phone, text message or e-mail if necessary.
I have been informed that this office follows the regulations of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for the Protection of patient privacy & security of personal information.

APPOINTMENT POLICY: Broken or missed appointments

I understand that a 48- hour notice (2 working days) must be given for the cancellation of any appointment, and failure to do so will result in a "broken appointment" fee charged to my account based on the following fee schedule:
1st missed appointment fee: $50.00
1st missed surgical appointment fee: $150.00
2nd missed (broken appointment): $ 250.00 and it may result in dismissal from the practice as a patient.
I understand that insurance does not cover any of the "broken appointment" fees based on the above fee schedule. I also understand that the broken appointment fee will apply no matter what reason or excuse given by me for the broken appointment.
Late arrivals (over 30minutes) may be charged for broken appointments and/or rescheduled for another day.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

PATIENT PRIVACY NOTICE (Required by HIPPA*)

Drs. Christopher, Favagehi and Traboulsi

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTHCARE OERATIONS ONLY.

We hereby inform you that our office will keep your information confidential except in the following cases: Filing insurance claims, pre-determinations and collection attorney, Information needed to carry out your treatment, such as laboratory technicians, prescriptions to Pharmacist, and contacting Physicians, Other Dentist and Specialists.

Your consent for use and disclosure of health information to carry out treatment, payment activities and healthcare operations only is required:

☐

SECTION A: PATIENT GIVING CONSENT

Name: _____

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. In addition we may contact and/or report to your referring doctors, and/or contact your physicians for consultations. Furthermore, while keeping your privacy, clinical pictures, x-rays, may be used during teaching, in case presentations. **Notice of Privacy Practices**: You have the right to read our 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. 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:

Contact Person: Dr. Mehrdad Favagehi, 313 Park Avenue, #103, Falls Church, VA 22046, Phone: (703) 237 -3700

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, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your 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 on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

*HIPAA: Health Insurance Portability & Accountability Act of 1996