PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU – THANK YOU

PATIENT

LAST NAME:____ FIRST____ MI________

HOW DO YOU WISH TO BE ADDRESSED? __________________________________ DATE OF BIRTH ________________

(SINGLE/MARRIED/DIVORCED) (MALE/FEMALE) SOCIAL SECURITY NUMBER _______-_______-_______

ADDRESS ____ CITY ________________________ STATE_______ ZIP_______________

HOME # ______________________________ CELL # _____________________________ WORK # _____________________________

E-MAIL____ How did you hear about us?______________________________

EMPLOYER____ OCCUPATION________________________________

RESPONSIBLE PARTY

LAST NAME:_______________________________________ FIRST____ MI_________

DATE OF BIRTH ________________ (MALE/FEMALE) SOCIAL SECURITY NUMBER_______-_______-_______

ADDRESS ____ CITY ________________________ STATE_______ ZIP_______________

HOME # _________________ CELL # _________________ WORK # _________________ EMAIL________ ____________________

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY ___________________________________ PHONE NUMBER ______________________________

BILLING ADDRESS ____ CITY________________________ STATE_________ ZIP____________

POLICY ID OR SOCIAL SECURITY#____ GROUP#_____________________________

SUBSCRIBER NAME____ DATE OF BIRTH_____________________

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY ___________________________________ PHONE NUMBER ______________________________

BILLING ADDRESS ____ CITY________________________ STATE_________ ZIP____________

POLICY ID OR SOCIAL SECURITY#____ GROUP#_____________________________

SUBSCRIBER NAME____ DATE OF BIRTH_____________________

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health/dental care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health/dental care, advice and treatment to another dentist, 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 payment and or assignment of insurance benefits directly to Dr. Karina Vera-Lopez and/or Vera Dentistry, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of accounts. I authorize the use of my signature on all insurance submissions. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this page.

Responsible Party Signature____ **Date**__________________________

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
Bad Breath	☐	☐
Blisters on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chew on one side of mouth	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐
Smokeless tobacco	☐	☐
Dry mouth	☐	☐
Food collection between teeth	☐	☐
Clench or grind teeth	☐	☐
Growths or sore spots in your mouth	☐	☐
Gums swollen, tender or bleeding	☐	☐
Head, neck, mouth, jaw pain or aches	☐	☐
Lip or cheek biting	☐	☐

	Yes	No
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	☐
Orthodontic treatment	☐	☐
Nitrous Oxide	☐	☐
Periodontal treatment	☐	☐
Sensitivity to pressure or irritants (cold, heat, sweets)	☐	☐

How often do you floss? ______________________

How often do you brush? ______________________

Have you ever had an allergic reaction to Novocaine, 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 _____________________________ Physician's Office Number _________________ Date of last visit________

Physician's address ____ 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) Are you pregnant? ☐Yes ☐No Due date____________ Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Please check if you have/had:

	Yes	No
AIDS/HIV	☐	☐
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Bleeding abnormally with operations or surgery	☐	☐
Blood disease, clotting disorders	☐	☐
Cancer	☐	☐
Chemotherapy/Radiation treatments	☐	☐
Circulatory problems	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Dizziness/Fainting	☐	☐
Glaucoma	☐	☐
Headaches/Migraines	☐	☐
Heart murmur/problems	☐	☐
Hepatitis type ___________	☐	☐

	Yes	No
Heart surgery	☐	☐
Herpes	☐	☐
High cholesterol	☐	☐
High/Low blood pressure	☐	☐
Any immune deficiency	☐	☐
Jaundice	☐	☐
Kidney disease	☐	☐
Mitral valve prolapse	☐	☐
Nervous problems	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Pacemaker/Artificial heart valves	☐	☐
Psychiatric care	☐	☐
Respiratory disease/Shortness of breath	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Sinus trouble	☐	☐
Sickle cell anemia	☐	☐
Skin rash	☐	☐
Slow healing wounds	☐	☐
Special diet	☐	☐
Stroke	☐	☐

	Yes	No
Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐
unexplained Weight loss	☐	☐
Do you consume alcoholic beverages?	☐	☐
Allergic to: **Please Circle** Aspirin, Penicillin, Local Anesthetic, Barbiturates, Codeine, Iodine, or Sulfa		
	☐	☐

Please list any medications that you are currently taking: ____________________

____

____

____

____

____

____

AUTHORIZATION AND RELEASE

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

Responsible Party Signature____ **Date**__________________________

PATIENT LAST NAME: ________________________________ PATIENT FIRST NAME: _______________________

Vera Dentistry and affiliated companies, collectively known as "Karina Vera-Lopez, DDS", are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND *CARE CREDIT.**
- **VERA DENTISTRY PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

NOTICE OF PRIVACY PRACTICES

This notice describes how dental/health information about you may be used and disclosed and how you can get access to this information. I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of my or my child's protected health information to carry out treatment, payment activities, and dental care options. **PLEASE INTIAL___________**

MINORS ACCOMPANIED BY ADULT/UNACCOMPANIED MINORS

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.
The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card, or Discover. We do not accept American Express payments for visits by unaccompanied minors.

INSURANCE

Vera Dentistry provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If your or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Vera Dentistry staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to Vera Dentistry. However, if you are paid by the insurance company instead of Vera Dentistry, you then become responsible for the total account balance and payment would be expected immediately.
If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance. Insurance is your benefit and we cannot guarantee payment from insurance.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days or more. I understand that should my account be placed with a third party collection agency or their attorneys for collections, then I agree to be responsible for all costs incurred in the collection of my account, including attorney's fees, court cost and interest at 1.5% per month. (18% per annual maximum), and may be forwarded to credit bureaus. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $30.00.

MISSED APPOINTMENTS

Unless **cancelled at least 48 hours in advance**, our policy is to **charge for missed appointments at the rate of $50.00 per each 30 minutes of missed appointment time**. Please help us service you better by keeping scheduled appointments, **we reserve the right to reschedule any missed appointments after a grace period of 15 minutes**.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature______________________________________ **Date**_________________________________

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2015

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

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

Compliance Officer: Isabell Betancourt
Telephone: 703-590-4666 Fax: 703-897-1526
Address: 4321 Ridgewood Center Drive, Woodbridge, VA 22192

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care of treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

Our Responsibilities
We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. We will abide by the terms of this notice.

Uses and Disclosures

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health/dental information.

For Treatment: We may use and disclose health/dental information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your dental plan about treatment you are going to receive to determine whether your plan will cover it.

For Dental Care Operations: Members of the clinical staff and/or quality improvement team may use information in your dental record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health/dental information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health/dental information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health/dental information to protect your privacy.

Fundraising: We may contact you to raise funds for the facility; however, you have the right to elect not to receive such communications.

We may also use and disclose health information:

- To remind you that you have an appointment for dental care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about dental-related benefits or services;
- For population based activities relating to improving dental or reducing dental care costs;
- For conducting training programs or reviewing competence of health care professionals; and
- To a Medicaid eligibility database and any other dental Insurance database, as applicable.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services, emergency department and radiology, laboratory and certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health/dental information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard our information.

Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition. In addition, we may disclose health/dental information about you to an entity assisting in a disaster relief effort in order to assist with the provision of this notice.

Research: The use of dental information is important to develop new knowledge and improve dental care. We may use or disclose health/dental information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). You may also be contacted to participated in a research study.
Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its clinical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and dental care operations. Dentists, Specialists, Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Affiliated Covered Entity: Protected dental information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and dental care operations. Caregivers at other facilities may have access to protected dental information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.

Dental Information Exchange/Regional Dental Information Organization: Federal and state laws may permit us to participate in organizations with other dental/health care providers, insurers, and/or other dental/health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your dental records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

As required by law. We may disclose information when required to do so by law.

As permitted by law, we may also use and disclose dental/health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Correctional Institutions
- Workers Compensation Agents
- Military Command Authorities
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- A person or persons able to prevent or lessen a serious threat to health or safety

Law Enforcement: We may disclose dental/health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

For Judicial or Administrative Proceedings: We may disclose protected dental/health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

Authorization Required: We must obtain your written authorization in order to use or disclose psychotherapy notes, use or disclose your protected dental/health information for marketing purposes, or to sell your protected health information.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving dental health or reducing dental care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your dental record is the physical property of the dental care provider or facility that compiled it, you have the **Right to:**

- **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes dental and billing records. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to dental information, you may request that the denial be reviewed. Another licensed dental care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Amend:** If you feel the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.
  We may dent your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or dental care operations where an authorization was not required.
- **Request Restrictions:** You have the right to request a restriction or limitation on the health/dental information we use or disclose about you for treatment, payment or dental care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to the Facility Privacy Official.
- We are required to agree to your request **only** if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), **and** 2) your information pertains solely to health care services for which you have paid in full. **For other requests, we are not required to agree.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **Request Confidential Communications:** You have the right to request that we communicate with you about the medical/dental matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
- If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please obtain the required forms form the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE
We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at any of our facilities for evaluation or treatment, we will offer you a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with that facility's Compliance Officer. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION
Other uses and disclosures of dental/health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose dental/health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.