

WELCOME

About You

Today's Date:

Patient Name _____

Last Name

First Name

Middle Initial

If under 18 years old, then please give parent or guardian name:

Last Name

First Name

Middle Initial

What you prefer to be called _____ Male ☐ Female ☐

Birthdate: ____/____/____ Age: _____ SS# ____ - ____ - _____

Mailing Address: _____

City

State

Zip

Home Phone: (____) _____

Cell Phone (____) _____ Work Number (____) _____

Email Address: _____

What is the best number to reach you during the day? _____ May we leave a message? _____

May we contact you by ☐ Text messages ☐ Emails ☐ Both

May we email your dental statements to you? ☐ Yes ☐ No

How were you referred to our office? _____

Employer: _____

Address

City/ State

Zip

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Name of Your Primary Care Physician: _____

Emergency Contact Information

Whom should we contact? _____

Relation: _____

Home phone: (____) _____ Cell Phone: (____) _____

NAME:

Date:

MEDICAL INFORMATION

Have you ever been diagnosed with:	Yes	No	Have you ever been diagnosed with:	Yes	No
Diabetes Type 1 or Type 2 If so, list last blood sugar and HBA1C			History of Infective Endocarditis		
High / Low blood pressure			Liver Disease		
Asthma/ COPD/ Emphysema/Breathing problems			Congenital Heart defect		
Kidney Disease			Artificial Joints		
Ulcers			Cardiovascular Disease		
Gastritis			Mitral Valve Prolapse		
Hepatitis A, B or C			Tuberculosis		
HIV			Syphilis		
HPV			Glaucoma		
Herpes, Shingles or Chickenpox			Osteoporosis		
Thyroid Disorder			Arthritis		
Sleep Apnea			Bleeding Disorder		
			Cancer		

If yes, what type of cancer and what treatments have you received (radiation, chemotherapy)_____

Are you receiving or have you ever received IV Bisphosphonate treatments?_____

If so, please list dose, start/stop dates and name of physician._____

Do you take or have you ever taken osteoporosis medication (ie: Fosamax, Boniva, Actonel, Reclast)?_____

If so, please give the medication name, start/stop dates and dose._____

Do you take any blood thinner medications (ie: Coumadin, Jantoven, Rivaroxaben, Xarelto)?_____

If so, please give the medication name and dose._____

Do you smoke? ☐ Yes ☐ No If yes, how much? (packs or cigarettes per day) _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much?_____

Have you ever had a drug addiction? ☐ Yes ☐ No

Do you have pain in your jaw or feel jaw soreness when you wake up? ____YES ____NO

Do you feel dizzy in the dental chair or need the chair to be lowered or raised slowly? ____YES____NO

Colleen Moreno, D.D.S
A Division of Atlantic Dental Care, PLC
524 Albemarle Drive, Suite 9, Chesapeake VA 23322

Patient Name _____ **REGISTRATION AUTHORIZATION**

AUTHORIZATION FOR DENTAL AND/OR DIAGNOSTIC TREATMENT

I, the undersigned, request treatment for either myself or my child/ward and hereby authorize Dr. Colleen Moreno (and whomever they may designate as their assistants, including hygienists) to treat me or my child/ward in ways they determine therapeutically necessary. I understand that this treatment may include tests, examinations, x-rays, fluoride treatments, administration of drugs, and medical or surgical procedures.

Initial

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

The laws of Virginia authorize health care providers to test patients for HIV antibodies when the health care provider is exposed to body fluids of a patient. In the event of exposure, I understand that I will be deemed to have consented to testing, and consent to release test results to the health care worker who may have been exposed. Prior to testing, I will be informed and given an opportunity to ask questions.

Initial

ASSIGNMENT OF BENEFITS AND AGREEMENT TO PAY FOR SERVICES

I hereby irrevocably authorize my insurance company, Medicare or other provider of my health care benefits to pay any of my benefits directly to Dr. Colleen Moreno in payment for their respective services rendered on my account and on the account of my child/ward. We will file your insurance as a courtesy to you. I agree to pay Dr. Colleen Moreno for any charges not paid for by my health care benefits.

Initial

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize release of any information relating to dental treatment to my insurance company. I also authorize release of any necessary information, including insurance information, to a dental specialty provider in the event that I am referred to a dental specialist for evaluation or treatment. I also give permission to release my records (at my request) to a new dental provider should I transfer to another dental practice.

Initial

BROKEN APPOINTMENTS AND BILLING FEES and COLLECTIONS

As a courtesy, we will contact you to remind of your next dental appointment. It is my responsibility to contact the office if I should be unable to keep any scheduled appointment. I understand that a charge will be made for broken or cancelled appointments without prior notification of 24 hours. I also understand that a repeat billing fee will be charged on accounts over 30 days past due. I agree that Dr. Colleen or their agents may contact me electronically by text, email and/or via telephone regarding my account balance.

Initial

CERTIFICATIONS

I certify that this form has been fully explained to me and that I understand its contents. Furthermore, I permit a copy of this authorizing document to be used in place of the original.

I certify that I am the patient, the patient's parent or legal guardian and have the authority to grant this consent.

I certify that all statements and documents are true and correct. I understand that false statements or documents, or concealment of a material fact may be prosecuted under federal or state laws.

Date

Patient/Legal Guardian signature

Relationship to patient

I understand that payment is due at the time that services are rendered. Any anticipated insurance payment will be factored in to the amount due, but it is only an ESTIMATE. The actual amount due may exceed our calculations. You will receive notice if a balance is due, and payment will be due within 14 days of the notice unless arrangements have been made prior to treatment. Any balance not paid within 90 days from date of service will be turned over for collection action if arrangements have not been made with the business manager. You will be responsible for any legal fees, collection fees and interest charges incurred in collecting your account.

Date _____ Patient/Legal Guardian signature _____

Signature Smiles
Dr Colleen Morneno, D.D.S.

(Name of Practice)

**Acknowledgement of Receipt of
Notice of Privacy Practices**

* You May Refuse to Sign This Acknowledgment*

I, _____, have received a copy of this office's
Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Insurance Information

Patient Name: _____

Primary Dental Insurance

Name of Insurance Carrier: _____

Subscriber's ID Number: _____

Group ID Number: _____

Insured's Name: _____

Insured's Date of Birth ____/____/____ Insured's SS # ____-____-____

Secondary Dental Insurance

Name of Insurance Carrier: _____

Subscriber's ID Number: _____

Group ID Number: _____

Insured's Name: _____

Insured's Date of Birth ____/____/____ Insured's SS # ____-____-____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims, or if I am referred to a dental specialty practice.
- I understand that the above information was completed to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided.

I understand that payment is due at the time that services are rendered. Any anticipated insurance payment will be factored in to the amount due, but it is only an ESTIMATE. The actual amount due may exceed our calculations. You will receive notice if a balance is due, and payment will be due within 14 days of the notice unless arrangements have been made prior to treatment. Any balance not paid within 90 days from date of service will be turned over for collection action if arrangements have not been made with the business manager. You will be responsible for any legal fees, collection fees and interest charges incurred in collecting your account.

Signed: _____ Date: _____

Dental History

Name: _____

Date: _____

Reason for today's visit _____

Are you experiencing pain? _____ Please rate the severity of your pain: none 1 2 3 4 5 6 7 8 9 10 extreme

Is your pain improving? ☐ worsening? ☐ or remaining the same? ☐

Please indicate if you are experiencing any of the following problems:

- | | |
|--|---|
| ☐ Discomfort, clicking or popping jaw | ☐ Lost or broken filling (s) |
| ☐ Red, swollen or bleeding gums | ☐ Teeth grinding |
| ☐ Sensitive tooth, teeth or gums | ☐ Broken/ chipped tooth |
| ☐ Blisters/Sores in or around mouth | ☐ Stained teeth |
| ☐ Other _____ | |

Have you been told you require antibiotic pre-medication before each dental visit? Yes ☐ No ☐ Don't know ☐

Date of Last dental exam ____/____/____ Were x-rays taken? ☐ Yes ☐ No

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

If not a "10", what would you like to change about your smile? _____

Have you ever had periodontal (gum) surgery? _____ If so, when? _____

Have you ever had a bad experience at the dentist or would you describe yourself as having dental anxiety? _____

How many times per day do you brush? _____ Times a week you floss? _____

Do you drink sodas or other beverages with added sugar? _____

Do you use a fluoride toothpaste? ☐ Yes ☐ No

FOR WOMEN:

Are you taking birth control pills? _____ How many children have you had? _____

Are you pregnant or trying to become pregnant? _____ Are you nursing? _____

FOR CHILDREN:

Does Child do any of the following? ☐ Thumb/finger sucking ☐ Mouth breathing ☐ Snore

☐ Tongue thrusting/Sucking

PATIENT NAME_____

Please list any previous surgeries and approximate year

Surgery	Year	Surgery	Year

Please list all medication **ALLERGIES**

Medication:_____Reaction_____

Medication:_____Reaction_____

Medication:_____Reaction_____

Are you allergic to penicillin? _____Are you allergic to latex? _____

Allergic to nickel?_____

Please list all medications /supplements you are currently taking

Medication Name	Dose and Frequency	When did you start taking it?	What is it for?

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____

Update Date:_____Initials_____ Update Date:_____Initials_____

Due to changes in the HIPAA laws, I, _____, give my permission for Dr. Moreno and her staff to discuss my dental records including treatment, account/insurance information & appointments with the following person(s):

___Spouse ___Parents ___Other (please name)_____

My e-mail address is:_____

****I agree that by giving my email address and text number that Signature Smiles or their agents may contact me electronically. I also understand that the text messages and appt reminder emails I will receive are not encrypted.***

Home Address:_____ ZipCode _____

Home Telephone:_____ Work _____

Cell phone _____

May we contact you by text message? ___Yes ___No

Electronic Billing

We send our Dental statements by **encrypted** email. This will not allow access if you try to open it by any other email than the one we have on file for you. We can also send it unencrypted for more accessibility (phone/tablet/other email).

Please select one of the following:

_____ I want only encrypted email sent. It will have limited accessibility

_____ I agree to allow Signature Smiles to send my statement by unencrypted email

_____ Mail Statement

Signature:_____ Date _____