NORBO DENTAL

NORBO DENTAL, PLLC • Loudoun Valley Prof. Bldg. • 441 East Main St. / P.O. Box 300 • Purcellville, VA 20134 • Phone: 540-338-7325

1 PATIENT INFORMATION

Date_____/_____/_____SSN #_____

Patient Name_____
Last Name

_____
First Name Middle Initial

Email_____

Address_____

City_____

State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____/____/_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for_____yrs

Patient Employer/School/College_____

Occupation_____

Spouse's Name_____

Birthdate_____/_____/_____ SSN#_____

Spouse's Employer_____

Whom may we thank for referring you?_____

2 DENTAL INSURANCE

Insurance Co._____Group #_____

Subscriber's Name_____

Birthdate_____/_____/_____SS#_____

Relationship to Patient_____

Is patient covered by additional insurance? Yes ☐ No ☐

ASSIGNMENT AND RELEASE : I certify that I, and/or my dependent(s), have insurance coverage with the above named company and assign directly to Norbo Dental, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

X _____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____
Date Relationship to Patient

3 PHONE NUMBERS

Home ( )_____Work ( )_____ Ext._____ Cell ( )_____

Best time/place to reach you_____ Emergency Contact Name_____
(Specify someone who does not live in your household)

Relationship_____ Emergency Contact Phone_____

4 RESPONSIBLE PARTY

Person Financially Responsible for Account_____Relationship to Patient_____

Address_____Home Phone ( )_____

Driver's License #_____SS#_____Birthdate_____/_____/_____

Currently a Patient in our office: ☐ Yes ☐ No Email_____Cell ( )_____

5 DENTAL HISTORY

Reason for today's visit_____

_____

Former Dentist_____

City/State_____

Date of last dental visit_____

Date of last dental x-ray_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath Yes ☐ No ☐
Bleeding Gums Yes ☐ No ☐
Blisters on lips or mouth Yes ☐ No ☐
Burning Sensation on tongue Yes ☐ No ☐
Chew on one side of mouth Yes ☐ No ☐
Cigarette, pipe or cigar smoker Yes ☐ No ☐
Clicking or popping jaw Yes ☐ No ☐
Dry mouth Yes ☐ No ☐
Fingernail biting Yes ☐ No ☐
Food collection between teeth Yes ☐ No ☐
Foreign objects Yes ☐ No ☐
Grinding teeth Yes ☐ No ☐
Gums swollen or tender Yes ☐ No ☐
Jaw pain or tiredness Yes ☐ No ☐
Lip or cheek biting Yes ☐ No ☐
Loose teeth or broken fillings Yes ☐ No ☐
Mouth Breathing Yes ☐ No ☐
Mouth pain, brushing Yes ☐ No ☐
Orthodontic treatment Yes ☐ No ☐
Pain around ear Yes ☐ No ☐
Periodontal treatment Yes ☐ No ☐
Sensitivity to cold Yes ☐ No ☐
Sensitivity to heat Yes ☐ No ☐
Sensitivity to sweets Yes ☐ No ☐
Sensitivity when biting Yes ☐ No ☐
Sores or growths in mouth Yes ☐ No ☐

How often do you floss?_____

_____

How often do you brush?_____

_____

6 HEALTH HISTORY

Physican's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs to strengthen bones (bisphosponate)? Yes ☐ No ☐

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV Yes ☐ No ☐
Anemia Yes ☐ No ☐
Arthritis, Rheumatism Yes ☐ No ☐
Artificial Heart Valves Yes ☐ No ☐
Artifical Joints (pre-med) Yes ☐ No ☐
Year_____
Asthma Yes ☐ No ☐
Back Problems Yes ☐ No ☐
Bleeding abnormally, (extractions or surgery) Yes ☐ No ☐
Blood Disease Yes ☐ No ☐
Cancer Yes ☐ No ☐
Chemical Dependency Yes ☐ No ☐
Chemotherapy Yes ☐ No ☐
Circulatory Problems Yes ☐ No ☐
Congenital Heart Lesions Yes ☐ No ☐
Cortisone Treatments Yes ☐ No ☐
Cough, persistent or bloody Yes ☐ No ☐
Diabetes (insulin controlled) Yes ☐ No ☐
Emphysema Yes ☐ No ☐
Epilepsy Yes ☐ No ☐
Fainting or Dizziness Yes ☐ No ☐
Glaucoma Yes ☐ No ☐
Headaches Yes ☐ No ☐
Heart Murmur Yes ☐ No ☐
Heart Problems (Pre-med) Yes ☐ No ☐
Hepatitis Type_____ Yes ☐ No ☐
Herpes Yes ☐ No ☐
High Blood Pressure Yes ☐ No ☐
Jaundice Yes ☐ No ☐
Jaw Pain Yes ☐ No ☐
Kidney Disease Yes ☐ No ☐
Liver Disease Yes ☐ No ☐
Low Blood Pressure Yes ☐ No ☐
Mitral Valve Prolapse Yes ☐ No ☐
Nervous Problems Yes ☐ No ☐
Pacemaker Yes ☐ No ☐
Radiation Treatment Yes ☐ No ☐
Respiratory Disease Yes ☐ No ☐
Rheumatic Fever Yes ☐ No ☐
Scarlet Fever Yes ☐ No ☐
Shortness of Breath Yes ☐ No ☐
Sinus Trouble Yes ☐ No ☐
Skin Rash Yes ☐ No ☐
Stroke Yes ☐ No ☐
Swollen Feet or Ankles Yes ☐ No ☐
Swollen Neck Glands Yes ☐ No ☐
Thyroid Problems Yes ☐ No ☐
Tuberculosis Yes ☐ No ☐
Tumor or growth on head/neck Yes ☐ No ☐
Ulcer Yes ☐ No ☐
Venereal Disease Yes ☐ No ☐
Weight Loss, unexplained Yes ☐ No ☐

Women: Are you pregnant? Yes ☐ No ☐ Due Date_____ Are you Nursing? Yes ☐ No ☐ Taking Birth Control? Yes ☐ No ☐

MEDICATIONS: Please list medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name_____Phone Number ( )_____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic
☐ Barbiturates (Sleeping Pills) ☐ Penicillin
☐ Codeine ☐ Sulfa
☐ Iodine ☐ Other_____
☐ Latex ☐ NONE_____

NORBO DENTAL

Notice of Privacy Practices Acknowledgement

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature: **X**_____Date:_____

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____Reason:_____

_____

NORBO DENTAL

Policies of Practice

PERMISSION FOR TREATMENT

This is to certify that I, undersigned, (patient, parent, guardian or personal representative), consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated; and I will assume responsibility for fees associated with those procedures.

FINANCIAL AGREEMENT

It is the policy of our office to collect any payments due at time services are rendered. As a courtesy we will file your insurance claim. This does not relieve you from your responsibility of payment. Dental insurance is an agreement between the patient, your employer and insurance company. It is the patient's responsibility to notify the office if any insurance plan changes. Patients, parents, guardians or personal representatives are responsible for their portion of all fees for services rendered. We accept cash, checks, Visa, MasterCard and Discover. All accounts deemed delinquent will be turned over to a collection agency.

CANCELLATION POLICY

The staff at Norbo Dental strive to provide excellent care to each patient in a timely manner. We ask that you call our office if you are unable to attend your scheduled appointment. If it is necessary to cancel, we require that you call at least 24 weekday hours before your appointed time. We reserve the right to charge a $45.00 fee for a cancellation with less than 24 hours notice or for a broken appointment in which the patient does not show for the appointment.

PRACTICE DISMISSAL

A patient or family may be dismissed from our practice for various reasons. We will work with you in all aspects of care and finances but cases of multiple broken or late appointments, noncompliance with dental care, nonpayment, or undesirable behavior toward any staff or other patients may lead to dismissal.

SIGNIFICANT EXPOSURE

SIGNIFICANT EXPOSURE-Section 32.1-45.1(A) and (B), Code of Va. (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitis virus is considered to have been given by the patient and/or healthcare worker thereby granting a medical facility the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of the local medical facility.

By signing below, I agree to abide by the terms as stated in the Policies of Practice.

X _____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Thank You

We would like to thank you for choosing our office for your dental needs. Our policy is to provide you with the best treatment possible with the most current techniques available. Most important we are here to help you and your family in a comfortable environment. We are available to answer any questions regarding your care or financial needs. Thank you for placing your trust in our practice.

AUTHORIZATION
To Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care doctors, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you may want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "Do not release information" box below.

Authorization to speak with family/friend, including spouse:

Name of Authorized Person(s)_____

Relationship to Patient_____

Phone Number_____

Please check information you authorize to be shared with the person named.

- ☐ Appointments
- ☐ Financial Obligations
- ☐ Dental Treatment
- ☐ Insurance

Authorization to speak with family or friend:

Name of Authorized Person(s)_____

Relationship to Patient_____

Phone Number_____

Please check information you authorize to be shared with the person named.

- ☐ Appointments
- ☐ Financial Obligations
- ☐ Dental Treatment
- ☐ Insurance

Authorization to speak with family or friend:

Name of Authorized Person(s)_____

Relationship to Patient_____

Phone Number_____

Please check information you authorize to be shared with the person named.

- ☐ Appointments
- ☐ Financial Obligations
- ☐ Dental Treatment
- ☐ Insurance

Norbo Dental, PLLC will use any and all numbers provided by the patient on the Patient Registration Form to leave messages on voice mail for appointment reminders, and to notify the patient that the staff would like to discuss procedures or insurance matters.

☐ **DO NOT release information to anyone.**

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify this office should I wish to change one or more contacts listed above.

Patients Name _____ **Date of Birth**_____

X_____ **Date**_____

SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE