WELCOME TO MCLEAN DENTAL CARE!

Patient Registration

Name:________________________________

Prefers to be called: ____________________

Sex: Male Female Date of Birth: ___________

Single Married Divorced Child Other

S.S.#:______________________________

Address: ____________________________

____

____

City State Zip

E-mail: __________________________

Home #: ___________ Work #:__________

Fax #: ______________ Other #:__________

Best method of contact (to leave a message)

____

Emergency Contact

Name: ______________________________

Relation: ____________________________

Home #:______________________________

Work #_______________________________

Whom may we thank for referring you?

Name: _____________________________

Pre-Medication:

Do you premedicate for dental treatment?

YES ________________ NO ____

If yes, what medications have been previously prescribed: _____________________

Pharmacy Information: Address: _

Phone:

____

I authorize this practice to leave messages regarding my dental appointments/conditions with:

Household Family Member	Yes No	Personal Cell Phone	Yes No
Home Answering Machine	Yes No	Work Answering Machine	Yes No

Acknowledgement of McLean Dental Care Policy

I understand and give Dr. Cecilia Gyllenhoff/ Dr. Samuel Cappiello permission to perform the dental treatment. I understand the treatment plan will be described to me and I can decline any treatment set forth at my own will.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless arrangements have been made. As a courtesy, McLean Dental Care will file insurance claims on my behalf.

I understand my appointments are reserved especially for me and I agree to give 48 hours notice of any changes.

SIGNATURE or SIGNATURE OF GUARDIAN_______________________ DATE____________

PATIENT DENTAL HISTORY

Welcome to McLean Dental Care! So that we may provide you with the best possible care, please complete **both sides** of this medical/dental history form. All info. Provided is completely confidential.

Last Name	First Name	Middle Initial	Prefers to be called:
Date of Last Dental:	Visit:	Cleaning:	X-Rays:
What was done at your last dental visit?			
Previous Dentist's Name:	Address & Telephone:		
How often do you have dental examinations?			
How often do you brush?			
What other dental aids do you use? (toothpick, mouthwash, etc.)			
Do you have any dental problems now? Y N describe:			

Question		
Are you teeth sensitive to hot or cold? Y N sweets?	Y	N
Do you have sensitivity when biting or chewing?	Y	N
Have you noticed any mouth odors or bad tastes?	Y	N
Do you frequently get cold sores, blisters, or other oral lesions?	Y	N
Do your gums bleed or hurt?	Y	N
Have your parents experienced gum disease or tooth loss?	Y	N
Have you noticed any loose teeth or change in your bite?	Y	N
Does food tend to become caught in between your teeth?	Y	N
Do you: clench or grind your teeth while awake or asleep?	Y	N
Bit your lips or cheeks regularly?	Y	N
Hold foreign objects between your teeth?	Y	N
Mouth breathe while asleep or awake?	Y	N
Have tired jaws, especially in the morning?	Y	N
Do you smoke or chew tobacco?	Y	N
Have you ever had:		
orthodontic treatment Y N oral surgery	Y	N
periodontal treatment Y N bite adjustment	Y	N
serious injury to the mouth or head? Y N describe:		
Have you ever experienced:		
clicking or popping of the jaw?	Y	N
Pain (joint, ear, side of face)?	Y	N
Difficulty in opening or closing of the mouth?	Y	N
Difficulty in chewing on either side of the mouth?	Y	N
Aches in the head, shoulder, neck?	Y	N
Sore muscles in your neck or shoulders?	Y	N

Have you been under the care of a medical doctor
during the past two years? Y N explain:
Physicians name? Telephone:

Current medications/drugs over the past 2 yrs? Y N
Please list name and dosage:

Are you aware of having allergic reactions to any medications/substances? Y N
If yes, please list/describe:

Have you been a patient in the hospital in the past 5 yrs? Y N
If yes, please describe:

Indicate which of the following you have had, or have at the present:

Heart (surgery, disease, attack)	Y	N	Ulcers?	Y	N
Chest pain	Y	N	Diabetes	Y	N
Congenital Heart Disease	Y	N	Thyroid Problems	Y	N
Heart Murmur	Y	N	Glaucoma	Y	N
High Blood Pressure	Y	N	Contact Lenses	Y	N
Mitral Valve Prolapse	Y	N	Emphysema	Y	N
Artificial Heart Valve	Y	N	Chronic Cough	Y	N
Heart Pacemaker	Y	N	Tuberculosis	Y	N
Rheumatic Fever	Y	N	Asthma	Y	N
Arthritis/Rheumatism	Y	N	Hay Fever	Y	N
Cortisone Medication	Y	N	Latex Sensitive	Y	N
Swollen Ankles	Y	N	Sinus Trouble	Y	N
Stroke	Y	N	Radiation Therapy	Y	N
Diet (special/restricted)	Y	N	Chemotherapy	Y	N
Artificial Joints	Y	N	Tumors	Y	N
Kidney Trouble	Y	N	Hepatitis A or B	Y	N
Bruise Easily	Y	N	Venereal Disease	Y	N
Liver Disease	Y	N	AIDS	Y	N
Yellow Jaundice	Y	N	HIV Positive	Y	N
Neurological Disorders	Y	N	Cold Sores/Blisters	Y	N
Epilepsy/Seizures	Y	N	Blood Transfusion	Y	N
Fainting Dizziness	Y	N	Hemophilia	Y	N
Psychiatric/Psychological Care	Y	N	Sickle Cell Disease	Y	N

Do you use more than 2 pillows to sleep? Y N
Have you lost or gained more than 10 pounds in the past yr? Y N
Do you have, or have you had, any disease/condition not listed? Y N
If so, please list:

WOMEN: Are you pregnant? Y N
If yes, how many months? Are you nursing? Y N
Do you use birth control pills? Y N

I understand the above information is necessary to provide me with dental care in a safe efficient manner.
I have answered all questions to the best of my knowledge. Should further information be needed,
you have my permission to ask the respective health care provider or agency, which may release such
information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: Date:

MCLEAN DENTAL CARE

NOTICE OF "DEEMED CONSENT" TO BLOOD TESTING IN BLOODBORNE PATHOGEN EXPOSURE INCIDENTS

As health care providers, we are required by s32.1-45.1 of the Code of Virginia, as amended, to give you the following notice:

If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV), Hepatitis B (HBV), and Hepatitis C (HCV). A physician or other health care provider will tell you the result of the test.

If you should be directly exposed to blood or body fluids of one of our health care professionals, workers, or employees in a way that my transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), Hepatitis B (HBV), and Hepatitis C (HCV). A physician or other health care provider will tell you and that person the result of the test.

I have been made aware of the Virginia law pertaining to exposure incidents.

Signature: ____

Date: ____________________________________

Financial Agreement

Just as it is our policy to "inform before we perform," we also feel that it is important to outline our financial agreement for you to review and understand as we move forward with our relationship. Our Patient Facilitator or Business Manager would be happy to answer any questions.

Payment

We ask that you plan to pay in full for your appointment at the time of treatment. We will do our part to notify you prior to your appointment with an *estimate* of the fees involved with your treatment. For larger cases, our patient facilitator will meet with you to discuss treatment fees and payment options.

We are happy to provide you with a variety of payment options. We accept cash, checks, all major credit cards and offer third party financing through Care Credit and Chase Health Advantage. Our patient facilitator is available to discuss these options with you at any time.

McLean Dental Care is not part of any insurance provider network and does not accept assignment of benefits. As a courtesy, we are happy to file your insurance claim along with all of the supportive documentation required to your primary insurance carrier. The payment of benefits from your insurance company will be made directly to you. Any disagreements or appeals regarding coverage should be discussed between you and your insurance carrier or employer.

We ask that if you are sending a child to our office without a parent that you make arrangements for payment either prior to the appointment or by sending a form of payment along with the child.

Reservations & Cancellations

We do understand that emergencies happen and that schedules change. We respect the time that you have set aside in your busy schedule and we will do our best to keep to that schedule so that you will be done on time. We do ask that if you cannot make your appointment, to please notify us within 48 hours so that we can make arrangements to fill your spot with another patient. A fee will be charged to your account for any canceled appointments without 48 hours notice. Our fee schedule is as follows: $25 for the first cancellation or no show, $75 for the second, and the full value of the appointment missed for the third.

When performing procedures that are two and a half hours or longer, a room reservation is requested when the appointment is scheduled. This is a *non-refundable* deposit if the appointment is changed or cancelled without 48 hours notice; otherwise, the reservation fee will go towards the total fee for the treatment being performed. The deposit is calculated as 25% of the total visit fee and is rounded to the nearest hundred dollars.

Confirmations

When reservations are made, please document them. As a courtesy, we confirm reservations 48 hours in advance either by phone or e-mail. Please indicate which method is best for you.

____

Financial Agreement Statement

I, The Undersigned, hereby agree to pay the above named dental practice all fees due for services rendered. Payment is to be made at the time of service regardless of insurance coverage.

I understand that payment of my bill is my legal obligation as the patient. All filing of insurance papers and confirmation of insurance payments to be made by my insurance carrier are my responsibility, as is determining providers covered by my current insurance. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow through or confirmation.

If this account is placed in the hands of an attorney for collection, I agree to pay attorney fees of thirty-three and one-third percent of the unpaid principal and interest owing, plus all court costs and interest. Interest is charged at the rate of one and one-half percent per month (18% ARP), beginning 30 days after the monies have become due or expenses have been incurred.

I also agree that this agreement shall cover all services for my spouse and any dependents and will remain in full force and effect until revoked by me in writing.

I further agree to pay returned check charges of $30 per returned check.

Patient Signature or Responsible Party: ________________________ _______________

Date: ________________________

McLean Dental Care
6707 Old Dominion Drive, Ste. 200, McLean, VA 22101
703-734-0100 office, 703-734-0115 fax

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW THIS NOTICE CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes **effect on 09/23/2013,** and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing

us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities; however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of

Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Anita Borum-White

Address: 6707 Old Dominion Drive, Ste. 200, McLean, VA 22101

Telephone: 703-734-0100

Fax: 703-734-0115

Email: mdc@mcleandentalcare.com

McLean Dental Care
6707 Old Dominion Drive, Ste. 200, McLean, VA 22101
703-734-0100 office, 703-734-0115 fax

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of McLean Dental Care's Notice of Privacy Practices, which has an effective **date of 09/23/2013,** and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

______________________________________ ____________________
Signature of Patient or Patient's Representative Date

____
Print Name

____
Relationship to Patient (If not signed by the Patient)

McLean Dental Care
6707 Old Dominion Drive
Suite 200
McLean, VA 22101
703-734-0100

PERMISSION FOR COMMUNUICATION

____ ___________________________
(Print name of the patient) (Birth date)

____ ___________________________
(Street address) (City, state, zip code)

This authorization permits discussion regarding any medical/dental condition that would impact my dental care.

I permit McLean Dental Care, to discuss my medical/dental information, in person, by telephone, or in written form with the following individuals:

Name	Phone Number	Relationship
1.________________________________	____________________	_____________
2.________________________________	____________________	_____________
3.________________________________	____________________	_____________

This authorization will remain effect until the patient notifies McLean Dental Care in writing that this authorization is to be terminated.

Patient's Signature: ______________________________ Date: _______________

INSTRUCTIONS: Complete, sign and send to McLean Dental Care:
6707 Old Dominion Drive, Suite 200 Mclean, VA 22101
Fax: 703-734-0115 or email mdc@mcleandentacare.com