Henritze Dental Group Steven N. Anama, DDS

4119 Brandon Ave. SW | ROANOKE VA, 24018 | (540) 776-6555
Email: brandon@henritzedental.com Website: www.henritzedental.com

Patient Information

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

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Child ☐ Other_____

Address: _____
Street Apartment #

_____
City State Zip Code

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

Social Security #: _____ Birth Date: _____

Email Address: _____

Person to notify in case of emergency: _____Phone:_____

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Health Information

WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No
If YES, when is your Due Date?_____

Have you ever HAD or DO HAVE any of the following? Please check those that apply:

☐ AIDS/HIV positive
☐ Allergies to medicines
☐ Anemia
☐ Arthritis
☐ Artificial Joints
Type:_____
☐ Artificial Heart Valves
☐ Arrhythmia
☐ Asthma
☐ Blood Disease
☐ Cancer
Type:_____
☐ Depression
☐ Diabetes
Type:_____
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Fibromyalgia
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head/Neck Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
Type_____
☐ High Blood Pressure
☐ High Cholesterol
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Lung Disease
☐ Mental Illness
☐ Nervous Illness
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pacemaker
☐ Psychiatric Treatment
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sexually Transmitted Disease_____
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid
☐ Tuberculosis
☐ Tumors
☐ Ulcers

OTHER:
☐ _____
☐ _____
☐ _____
☐ _____
☐ I have no medical problems
☐ I am taking no medications

- Have you ever taken bisphosphonate medication (i.e. Fosamax, Actonel, Boniva, Aredia, Zometa, etc…)? ☐ Yes ☐ No
- Have you ever been told you needed to be premedicated for dental work? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Pharmacy (Name, Address, Phone#): _____
- Are you currently taking any medications (Over-The Counter or Prescriptions)? ☐ Yes ☐ No
  If YES, please list on MEDICATION LIST form (next page).
- Please List Medications you have ALLERGIES or ADVERSE REACTIONS to:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____

MEDICATION LIST

NAME: _____
DOB: _____
DATE (as of): _____

DRUG	DOSAGE(mg)	FREQUENCY	PURPOSE/TREATING WHAT?

- Are you under the care of a Primary Care physician? ☐ Yes ☐ No
  If yes, Physician (Name, Address, Phone#): _____
  _____
- Do you have any Health conditions, Surgeries, diseases, etc., not listed that we should be aware of? ☐ Yes ☐ No
  If yes, please explain: _____
  _____

Dental Information

Reason for this visit: _____
Date of Last Dental Checkup: _____
Previous Dentist (Name, Address, Phone#): _____
_____

Please mark any of the following if the answer is YES:

- ☐ Do you wake up in the morning with headaches?
- ☐ Does your jaw make clicking/popping sounds when opening/closing?
- ☐ Difficulty opening or closing your mouth?
- ☐ Clenching or grinding your teeth?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do your gums bleed when you brush or floss?
- ☐ Do you have any swelling or bumps in the mouth?
- ☐ Frequent mouth sores on the lips or in the mouth?
- ☐ Do you have persistent swollen glands?
- ☐ Burning tongue or lips?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening/being lost?
- ☐ Do you currently have any Dental Implants, Dentures or Partials?
- ☐ Have you had Orthodontic treatment (Braces)?

Have you ever been told you have Periodontal Disease (gum disease, or pyorrhea)? ☐ Yes ☐ No
If Yes, Date of last Periodontal Treatment: _____

How often do you brush per day? ☐ 1x ☐ 2x ☐ more than 2x
How often do you floss per day? ☐ 1x ☐ 2x ☐ more than 2x ☐ Never ☐ Occasionally

What type of toothbrush do you currently use? ☐ Manual ☐ Electric
If Manual, ☐ Soft ☐ Medium ☐ Hard
If Electric, what brand? _____

Do you use any of the following mouth rinses? ☐ ACT or Fluoride Rinse ☐ Listerine ☐ Other_____
If so, how often and how much? _____
Do you drink sodas or sweet tea? ☐ Yes ☐ No
If Yes, how often and how much? _____

Do you use tobacco (cigars, cigarettes, smokeless, snuff, or chew)?
If Yes, how long and how often (per day)? _____

If you could change anything about your mouth, teeth or smile, what would it be?
_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I understand that providing incorrect and/or inaccurate information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status, condition or medications taking. I also understand that this information will be held in the strictest confidence.
I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate, and treatment with my informed consent.

_____ Relationship to patient: _____Date:_____
Signature of patient, parent or guardian completing this form

Responsible Party Information (if other than patient)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Dental Insurance Information

Primary

Subscriber's Name: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Referral Information

Whom may we thank for referring you to our practice? _____

Office/Financial Policy

Payment: We realize that every patient's financial situation is different. For this reason, we have provided several payment options to help you receive the dental care you need and deserve.

We accept Cash, Checks, Visa, MasterCard or Discover Card

Convenient Monthly Payment Plans[1] from CareCredit

- Allows you to pay over time
- No annual fees or pre-payment penalties

Payment is expected when services are rendered.

Insurance: For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

Our office is a participating provider for **Delta Dental** and **Cigna** dental insurance plans.

Based on your insurance plan, we will estimate your copay and ask for the patient portion at the time of treatment. Since we can only estimate your copay, you may receive a statement after your insurance is processed.

Copays and/or Deductibles are expected the day of treatment.

Finance Charges: A finance charge will be imposed on any overdue balances on your account not in compliance with agreed payment arrangements. The FINANCE CHARGE will be computed at the rate of (1.5%) per month or an ANNUAL PERCENTAGE RATE OF eighteen (18%) percent. The finance charge is computed by applying the periodic rate (1.5%) to the "overdue balance" (over 30 days) of your account.

Returned Checks: Our office charges $50 for checks returned for nonpayment.

Delinquent Accounts: If your account becomes delinquent and is sent to a collection agency, you are responsible for all costs and fees incurred associated with the collection of any unpaid balances. Dr. Anama reserves the right to dismiss any patient/family from the practice for nonpayment of their account. If a patient is allowed to return after a delinquent account becomes current, that patient will be cash for service only.

Appointments: Failure to show up for a scheduled appointment can result in a $100 broken appointment fee. We understand that sometimes there are circumstances beyond one's control which would result in a late, cancelled or missed appointment. Broken appointment fees are applied on a case by case basis following careful review of your account and appointment history.

Restorations: You have the option of restoring your teeth with either amalgam (metal) fillings or composite resin (tooth-colored) fillings. Our office will place either restoration based on each patient's dental situation and as agreed upon by the doctor and the patient. Keep in mind, individual insurance policies may vary on coverage of composites; some may "downgrade" to amalgam meaning the patient will be paying more "out-of pocket" expense for a composite restoration than an amalgam. Some may not pay at all. We encourage our patients to be familiar with their plan to eliminate disappointments with payment and reimbursement

Deposits: For larger, more comprehensive treatment appointments of $500 or more, a co-pay deposit may be required to secure the treatment appointment.

Transfer/Copy of Dental Records: If you need to have your records transferred/copied from our office to another or have your records transferred/copied to you, you will need to fill out and sign the necessary record release form. We reserve the right to charge up to $50.00 to copy your records. It may take up to 30 days to finalize your request.

Patient Consent for Services: I authorize the dentist to release any information and the records of any treatment or examinations rendered to me during the period of such dental care to third party payers and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me unless other arrangements have been made by me to pay directly to me.

I understand that my dental insurance may pay less than the actual bill for services and that I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED.

I understand that the fees quoted for dental treatment can only be guaranteed for a period of six months from the date of the patient examination.

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

_____

Patient, Parent or Guardian Signature Completing this Form Date Relationship to Patient

_____

Patient Name (Please Print)

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Patient Name: _____
Address: _____
Telephone: _____

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.

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 health information. A copy of our Notice accompanies this Consent. 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, 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, at any time by contacting:
Contact Person: Henritze Dental Group Dr. Steven Anama-HIPAA Administrator
Telephone: 540-776-6555
Address: 4119 Brandon Avenue Roanoke VA 24018

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 as described in the "Notice of Privacy Practices"

Signature: _____ Date: _____
Personal Representative: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THE CONSENT AFTER YOU SIGN IT