a wink & a smile

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: ____

Preferred / Nickname: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Soc Sec: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Work: _____ Ext: _____ Cellular: _____

E-mail: _____ *(appointment-related correspondences)*

Employer: _____ ○ Full time ○ Part Time ○Retired ○ Student

Policy Holder / Parent / Guardian *(If different from patient)*

First Name: _____ Last Name: _____ Middle Initial: ____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Mark if address is same as above

Address: _____ Address 2: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Work: _____ Ext: _____ Cellular: _____

E-mail: _____ Employment Status: ○ Full time ○ Part Time ○ Retired

Insurance Information

Primary Insurance *(Please provide card if available)* – Please supply as much information as possible.

Name of Insured: _____ Insured is: ○ Patient ○ Spouse ○ Parent ○ Other

*Insured ID #: _____ Insured Birth Date: _____

Employer: _____ Insur. Company: _____

City,State,Zip:_____ Address: _____

Group Number: _____ City,State,Zip: _____

**Required (social security or member ID)*

Secondary Insurance *(If applicable - please provide card if available)*

Name of Insured: _____ Insured is: ○ Patient ○ Spouse ○ Parent ○ Other

Insured ID #: _____ Insured Birth Date: _____

Employer: _____ Insur. Company: _____

City,State,Zip:_____ Address: _____

Group Number: _____ City,State,Zip: _____

Referred by: ○ **Mailer** ○ **Insurance** ○ **Patient:** _____ ○ **Other:** _____

Previous Doctor: _____ City,State: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

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Patient Name: _____ Date of Birth: _____ Date: _____

MEDICAL HISTORY

Are you under a physician's care now?	☐ No	☐ Yes	If yes: _____
Have you ever been hospitalized or had a major operation?	☐ No	☐ Yes	If yes: _____
Have you ever had a serious head or neck injury?	☐ No	☐ Yes	If yes: _____
Are you taking any medications, pills, or drugs?	☐ No	☐ Yes	If yes: _____
Do you take or have you taken Phen-Fen or Redux?	☐ No	☐ Yes	If yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ No	☐ Yes	If yes: _____
Are you on a special diet?	☐ No	☐ Yes	If yes: _____
Do you use tobacco?	☐ No	☐ Yes	If yes: _____

WOMEN: Are you… ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine Drugs ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ Yes: _____ Do you use controlled substances? ☐ No ☐ Yes If yes: _____

Do you have or have you had any of the following:

AIDS/HIV Positive □ Yes □ No	Cortisone Medicine □ Yes □ No	Hepatitis A □ Yes □ No	Recent Weight Loss □ Yes □ No
Alzheimer's Disease □ Yes □ No	Diabetes □ Yes □ No	Hepatitis B or C □ Yes □ No	Renal Dialysis □ Yes □ No
Anaphylaxis □ Yes □ No	Drug Addiction □ Yes □ No	Herpes □ Yes □ No	Rheumatic Fever □ Yes □ No
Anemia □ Yes □ No	Easily Winded □ Yes □ No	High Blood Pressure □ Yes □ No	Rheumatism □ Yes □ No
Angina □ Yes □ No	Emphysema □ Yes □ No	High Cholesterol □ Yes □ No	Scarlet Fever □ Yes □ No
Arthritis/Gout □ Yes □ No	Epilepsy or Seizure □ Yes □ No	Hives or Rash □ Yes □ No	Shingles □ Yes □ No
Artificial Heart Valve □ Yes □ No	Excessive Bleeding □ Yes □ No	Hypoglycemia □ Yes □ No	Sickle Cell Disease □ Yes □ No
Artificial Joint □ Yes □ No	Excessive Thirst □ Yes □ No	Irregular Heartbeat □ Yes □ No	Sinus Trouble □ Yes □ No
Asthma □ Yes □ No	Fainting Spells/Dizziness □ Yes □ No	Kidney Problems □ Yes □ No	Spina Bifida □ Yes □ No
Blood Disease □ Yes □ No	Frequent Cough □ Yes □ No	Leukemia □ Yes □ No	Stomach/Intestinal Disease □ Yes □ No
Blood Transfusion □ Yes □ No	Frequent Diarrhea □ Yes □ No	Liver Disease □ Yes □ No	Stroke □ Yes □ No
Breathing Problems □ Yes □ No	Genital Herpes □ Yes □ No	Low Blood Pressure □ Yes □ No	Swelling of Limbs □ Yes □ No
Bruise Easily □ Yes □ No	Glaucoma □ Yes □ No	Lung Disease □ Yes □ No	Thyroid Disease □ Yes □ No
Cancer □ Yes □ No	Hay Fever □ Yes □ No	Mitral Valve Prolapse □ Yes □ No	Tonsillitis □ Yes □ No
Chemotherapy □ Yes □ No	Heart Attack/Failure □ Yes □ No	Osteoporosis □ Yes □ No	Tuberculosis □ Yes □ No
Chest Pains □ Yes □ No	Heart Murmur □ Yes □ No	Pain in Jaw Joints □ Yes □ No	Tumors or Growths □ Yes □ No
Cold Sores/Fever Blisters □ Yes □ No	Heart Pacemaker □ Yes □ No	Parathyroid Disease □ Yes □ No	Ulcers □ Yes □ No
Congenital Heart Disorder □ Yes □ No	Heart Trouble/Disease □ Yes □ No	Psychiatric Care □ Yes □ No	Venereal Disease □ Yes □ No
Convulsions □ Yes □ No	Hemophilia □ Yes □ No	Radiation Treatments □ Yes □ No	Yellow Jaundice □ Yes □ No

Have you ever had any serious illness not listed above? □ Yes □ No Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the office of ANY changes in medical status.

Signature of Patient, Parent, or Guardian:

X _____ **Date:** _____

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Financial Policy & Receipt of Privacy Practices

It is our policy at a wink & a smile to provide all of our patients and customers with quality care. We will bill your insurance as a courtesy to you. We accept most PPO insurance plans and this is required as part of our contract with the insurance company. We do not accept any discount plans, HMO or DMO plans. Upon completion of treatment we will submit your claim. You will be responsible for your estimated portion on the date of your visit.

We give all of our patients an estimate of cost prior to completing treatment. In some cases, this is written and in some cases it is verbal. We do our very best to estimate your insurance payment to be as accurate as possible. Our estimates are based on information provided to us by your insurance company. Your payment may vary from the estimate provided to you by our office if there is a restriction, declaration, or clause in your insurance contract.

Please understand that the insurance policy is a contract between you and the insurance company. We will verify your insurance eligibility as a courtesy, **but it is your responsibility to know and understand your coverage**. Any service completed at a wink & a smile is your complete financial responsibility. We will file all primary and secondary insurance claims. Any balance on the account is due upon receipt of the statement. Any late or unpaid invoices/statements will be charged interest and late fees. If your account becomes past due (over 90 days) and we require a Collections Attorney, you will be liable for all fees associated with the Attorney, court costs, late fees and interest. Please keep in mind, these fees can be very expensive and will affect your credit.

_____ ***Scheduling:*** Dental appointments are normally one hour visits, with longer appointments for more extensive treatment. Your reservation requires the presence of a doctor, an assistant, and, in some cases, a hygienist. **We require a minimum of 2 business days' notice if you need to reschedule your visit.**

_____ As a courtesy, a wink & a smile will remind you of your upcoming appointment via Smile Reminder. Patients will receive automated phone calls, text messages, and emails to remind and confirm appointments previously made by the patient or authorized party on behalf of the patient. If at any time you or an authorized party chooses to opt-out of this service, you will be responsible for keeping all reserved appointments and **will not** receive communication from our office. Should you miss or cancel an appointment without 2 business days' notice, for any reason, you will be charged a failed reservation fee.

Short notice cancellation and failed reservation fees start at $100 for hygiene appointments and $150 for appointments with the doctor.

By signing this document, I agree to the Financial Policy of a wink & a smile and understand it is subject to change without notice.

SIGNED: _____ DATE: _____

Patient's Name: _____ Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT (Please see the attached laminated copy)

I acknowledge that I received a copy of Notice of Privacy Practices. A personal copy of this document can be made available to you at your request.

SIGNED: _____ DATE: _____

Patient's Name: _____ Relationship to Patient: _____

a wink & a smile
20745 Williamsport Place, Suite 120
Ashburn, VA 20147
571.333.1250

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

PATIENT NAME: _____

I authorize the professional office of a wink & a smile to release health information identifying me, including- if applicable, information about HIV infection or AIDS, information about substance abuse and/or-treatment, and information about mental health under the following terms and conditions:

1. Detailed description of the information to be released**: a wink & a smile ONLY releases treatment or related information to your insurance company.**

2. To person(s) identified by the patient:
   Name: _____ Relationship to Patient: _____
   Name: _____ Relationship to Patient: _____

3. Expiration date or event relating to the individual or purpose for the release.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. a wink & a smile, however, cannot submit any claims to any insurance company should you refuse to sign which will result in full office fees due at the time of service for any completed treatment.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient:

Print Name: _____ Relationship to Patient: _____