PATIENT INFORMATION **Today's Date** _____

Thank you for choosing our practice for your dental needs. Please complete this form in ink. I f you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. Please Print:

Name _____ Birth Date_____ Social Security #_____ M____F_____

Parent/Guardian Name_____BirthDate_____

Address _____City_____State_____Zip_____

Home Phone _____Work Phone _____Cell_____

Do you prefer to receive calls @ Home Work Cell

E-Mail Address:_____ Married_____ Single_____

Employer/School_____ Employer/School Phone_____

Employer/School Address_____City_____State_____Zip_____

Whom may we thank for referring you _____

Emergency Contact_____ Phone_____

INSURANCE INFORMATION

Name of Insured_____ Relationship to Pt_____

Birthdate _____ Social Security #_____

Name of Employer_____ Employer's Phone_____

Insurance Company_____ Group #_____

Insurance Co. Address_____City_____State_____Zip_____

SECONDARY INSURANCE

Name of Insured_____ Relationship to Pt_____

Birthdate _____ Social Security #_____

Name of Employer_____ Employer's Phone_____

Insurance Company_____ Group #_____

Insurance Co. Address_____City_____State_____Zip_____

DENTAL HISTORY

Former Dentist _____Date of Last Dental Care _____

Reason for today's Visit _____

Date of Last Exam _____ Date of last Dental X-Rays _____

How often do you brush? _____ How often do you floss? _____

Please circle any of the following that apply to you:

Bad Breath	Bleeding Gums
Clicking or popping Jaw	Food Collection Between Teeth
Grinding/Clenching teeth	Loose Teeth or Broken Fillings
Loose teeth or Broken fillings	Sensitivity to HOT/COLD
Periodontal Treatment	Sensitivity to Sweets
Sores or growths in your mouth	Sensitivity to Biting/Pressure

AUTHORIZATION I certify that I have read and understand to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information to third party payors. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of Patient (or Parent if a Minor) DATE

Lux Dental Center

Patient Medical History Form

Patient Name: _____ Birth Date: _____ Today's Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

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

☐ Other? If yes _____

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes _____

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 dental office of any changes in medical status.

Signature of Patient, Parent or Guardian

X _____ Date _____

LUX DENTAL CENTER

FINANCIAL AGREEMENT

We would like to take this time to welcome you to our office and explain how our billing service works.

PATIENTS WITHOUT INSURANCE COVERAGE

If you do not have dental coverage we do expect payment in full at the time of service. We accept Visa, MasterCard, Discover, American Express, Care Credit and of course cash. If you are not prepared to pay in full today please speak with a business assistant at the front desk before seeing the dentist.

PATIENTS WITH DENTAL INSURANCE

If you have dental insurance coverage, we will be happy to bill the insurance company for you. We do expect the patient to take full responsibility for their insurance company's actions and know what your benefits are. We, unfortunately, do not know what your insurance plan's benefits are. We can only estimate.

We bill your insurance company as a courtesy to you. The only time you are asked to pay out of your pocket is when the insurance company is estimated to cover less than 100%. When this occurs, you are expected to pay your estimated portion at the time of service. If your insurance does not cover what we expect them to pay—you are responsible for the remaining balance.

If you would like your recommended treatment to be pre-authorized, please ask one of the business assistants at the front desk. We do not automatically pre-authorize any treatment.

Please realize that once an appointment is made, you have reserved that time slot in the schedule. If you fail to give adequate notice (48 hours) you may be charged a minimum of $25 and a maximum not to exceed $50 per hour of appointment time reserved.

If you have any questions not answered in this letter please ask the front desk, we are always happy to help you in any way we can.

_____ _____

Parent or Guardian Signature Date

Address: 43761 Parkhurst Plaza, #132 ● Phone: (571)485-2900 ● Fax: (571)465-9470

GENERAL CONSENT FORM

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosage, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre estimate is given or a procedure has been pre-approved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Name Date

_____ _____

Witness Date

Address: 43761 Parkhurst Plaza, #132 ● Phone: (571)485-2900 ● Fax: (571)465-9470

NOTICE OF PRIVACY PRACTICES

Contact person: Dr. Lynn Alexander
lynnkiang@gmail.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1196 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may need to use/disclose your medical records only for the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

NOTICE OF PRIVACY PRACTICES

Contact person: Dr. Lynn Alexander
lynnkiang@gmail.com

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- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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 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 Private 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: _____

Permission granted to share HIPAA information with the following person/s:

_____

Signature: _____

Date: _____

Address: 43761 Parkhurst Plaza, #132 ● Phone: (571)485-2900 ● Fax: (571)465-9470

OFFICE USE ONLY

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:

E-MAIL ADDRESS: lynnkiang@gmail.com

Authorization to Release Dental Information

Patient name: _____ Release from: _____

Date of Birth: _____ Release to: _____

I request and authorize the above named doctor of health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information released includes drug abuse, alcohol abuse and psychological or psychiatric conditions if applicable.

Information Requested:

_____Copy of complete dental chart office

_____Copy of Dental X-rays conditions

Dates Covered:

_____All treatment rendered in this

_____Limited to treatment dates

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is correct to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that the action has already been taken to comply with request. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

Other conditions: A copy of this authorization or my signature thereon:
___may ___may not be used with the same effectiveness as an original.

*Patient or guardian signature*_____*Date*_____

Address: 43761 Parkhurst Plaza, #132 ● Phone: (571)485-2900 ● Fax: (571)465-9470