AUDREY MAIURANO, DDS, PC
FAMILY DENTISTRY

7841 Rolling Road, Suite C
Springfield, VA 22153
P: (703) 455-5555 F: (703) 455-5587

New Patient Form

General Patient Information

Patient's Last Name	First Name	MI	Preferred Name	Gender
Name of Responsible Party (If not the patient)	Relationship to Patient		Date of Birth	SSN

Home Address	City, State, ZIP	Home Tel.	Work Tel.
Occupation	Name of Employer	Employer's Address	E-mail

Marital Status

☐ Single ☐ Married ☐ Widowed

Full name of Spouse	Spouse's Employer, City	Work Tel.

Emergency Contact Information

Name of Emergency Contact	Relationship to Patient	
Home Tel.	Work Tel.	Mobile or Other Number

How did you hear about us? _____

Insurance Information

_____	_____	_____
Subscriber's Name	Subscriber's Date of Birth	SSN
_____	_____	
Relationship to Patient	Name of Subscriber's Employer	
_____	_____	_____
Insurance Company & Plan Name	Group ID Number	ID Number

Patient Medical History

Physician Information

Name of Physician: _____ Tel. No.: _____ Address:_____

Please check any of the following which apply to you:

☐ Anemia	☐ Cortisone Treatments	☐ Hemophilia	☐ Respiratory Disease
☐ Angina	☐ Cough, Persistent	☐ Hepatitis Type:___	☐ Rheumatic Fever
☐ Arthritis or Rheumatism	☐ Cough up blood	☐ Herpes	☐ Scarlet Fever
☐ Artificial Heart Valves	☐ Diabetes	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Joints/Replacements	☐ Emphysema	☐ HIV/AIDS	☐ Skin Rash
☐ Asthma	☐ Epilepsy/Convulsions	☐ Kidney Disease	☐ Smoking, Years:___
☐ Back Problems	☐ Fainting/Dizziness	☐ Leukemia	☐ Stroke
☐ Blood Disease	☐ Frequently Tired	☐ Liver Disease	☐ Swelling of Feet or Ankles
☐ Cancer	☐ Glaucoma	☐ Low Blood Pressure	☐ Thyroid Problems
☐ Chemical Dependency	☐ Heart Attack	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chest Pains	☐ Heart Disease	☐ Pacemaker	☐ Tuberculosis
☐ Circulatory Problems	☐ Heart Murmurs	☐ Radiation Treatment	☐ Ulcer
☐ Chemotherapy	☐ Heart Problems	☐ Recent Weight Loss	☐ Venereal Disease

☐ Other Medical issues not addressed previously: _____

_____

☐ Yes ☐ No Have you had any serious illnesses, operations or hospitalizations? (Please provide dates and reason)

_____

☐ Yes ☐ No Have you ever had a blood transfusion? (Please provide dates and reason)

_____

Medications you are currently taking:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Are you currently taking or have you ever taken any of the following:

☐ Actonel
☐ Boniva
☐ Fen-Phen/Redux
☐ Fosamax
☐ Vitamins/Supplements: (list below)
_____

Allergies:

☐ Aspirin
☐ Barbiturates
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic (Dental)
☐ Antibiotics (e.g. Penicillin)
☐ Sulfa
☐ Others:
_____
_____
_____

For Women Only – Check all that apply:

☐ Currently Pregnant ☐ Currently Nursing ☐ Currently on Birth Control*

* Certain medicines, such as antibiotics, can lower the effectiveness of oral contraceptives

Please review the above information for accuracy and completeness to help provide you the best possible care.

Certification

"I certify that I have read and understand all of the information written above. The questions above have been accurately answered to the best of my knowledge. I understand that providing false or misleading information can be detrimental to my health. I understand that it is my responsibility to inform the clinical staff for myself, or my ward (such as a minor), if any of the above answers become inaccurate or there are any changes in health."

_____ _____ _____

Name of Patient (please PRINT) | Name of Representative (if different) | Relationship to Patient

_____ _____

Signature of Patient/Representative | Date

Dental History and Primary Concerns

Last Dental Visit

Date: _____ Former Dentist: _____ City, State: _____

Check if any of the following have / had given you problems:

☐ Bad Breath
☐ Bleeding gums
☐ Broken fillings
☐ Clenching or grinding jaw
☐ Clicking or popping jaw
☐ Dry mouth
☐ Food collection between teeth
☐ Headaches
☐ Jaw Pain
☐ Loose teeth
☐ Orthodontic treatment
☐ Periodontal treatment
☐ Prolonged bleeding after extractions
☐ Sensitivity to biting/chewing
☐ Sensitivity to cold/hot
☐ Sensitivity to sweets
☐ Sores, lumps, growths in the mouth
☐ Swollen or tender gums

If you have checked any of the above, to the best of your ability, please provide information regarding when they last occurred, location and duration. _____
_____
_____

Do you have concerns regarding the following?

☐ Yes | ☐ No Appearance of your smile/teeth.

☐ Yes | ☐ No Fillings, crowns, or other previous dental treatment.

☐ Yes | ☐ No Jaw function.

☐ Yes | ☐ No Fear/Anxiety during dental treatments. Primary reasons, please check all that apply:

☐ Fear of pain ☐ Gagging ☐ Needles ☐ Sounds

☐ Other:_____
_____

Please list any methods you have used in the past that have helped you cope with your fear/anxiety:
_____
_____
_____

"I certify that the above responses are true and complete to the best of my knowledge."

_____ _____ _____
Name of Patient/Representative Signature of Patient/Representative Date

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Notice of Privacy Practices (HIPAA)

Purpose

This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding privacy practices.

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

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about your privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2018, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provide that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the change. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information 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, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Instructional Media and Case Studies: We may take photographs or videos of dental procedures for teaching or educational purposes for students, healthcare providers, or other oral healthcare related activities. No personal information except for identifying treatment will be disclosed.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgments disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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 pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health care information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate of patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you *$0.10 for each page, $20 per pro-rated hour of staff time* to locate and copy your health information, and *postage* if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before November 1, 2013. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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

Electronic Notice: If you receive this Notice on our Website or by electronic mail, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. 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.

Contact Officer:	Dr. Audrey Maiurano		
Telephone:	(703) 455-5555	Fax:	(703) 455-5587
E-mail:	info@springfielddentalclinic.com		
Address:	7841 Rolling Road, Suite C Springfield, VA 22153		

SIGNATURE

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights, I may contact the "Contact Officer" listed above."

Name of Patient or Guardian/Representative (please PRINT): _____

Signature of Patient or Guardian/Representative: _____ Date: _____

For Office Use Only

☐ Patient refused to sign

☐ Patient unable to sign because of the following reason(s):

- ☐ Communications barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify):

_____

_____

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General Information

Hours of Operation

Tuesday – Friday 8:00 AM – 5:00 PM

New Patient Initial Appointment will consist of the following:

- Review of Medical/Dental History
- Review of any medications currently being taken
- Oral examination to screen for dental disease/soft tissue abnormalities
- X-ray series to evaluate non-visual disease of teeth and bone
- Periodontal screening to detect disease of the supporting structures of teeth
- Treatment planning/consultation as necessary
- Consultation with previous dentist as required

Recall / Recare appointments will consist of the following:

- Update of medical/dental history
- Update of medication currently in use
- Review of last radiographs. Determination will be made if new x-rays are necessary based on the patient's homecare and current conditions. By policy, we do not take x-rays "by the calendar".

Notice: Insurance policies have specific timing for dental cleanings, if the patient chooses to have cleanings outside of the usual timing (every six months), it is the patient's responsibility to check insurance policy regarding this timing.

Treatment Plans

These plans are frequently needed in order to efficiently organize care and help the patient plan for the cost. Examples might include multiple crowns or fillings, bridges (fixed or removable) and periodontal root planing. When necessary, we can submit preauthorization to your insurance company before starting treatment.

Confirmation of appointments

We will try to reach you to confirm your appointments one or more days in advance. If we must leave a message, we ask that you call us to confirm. Appointments unconfirmed by you are subject to reuse if another patient needs them. We understand emergencies causing you to change appointments. However, we do require 48 hours cancellation notice to prevent a $50.00 broken appointment fee. Please keep us up to date with phone numbers and addresses.

Office Policies, Patient Consent and Release

Treatment

I, the undersigned, hereby authorize Dr. Maiurano and the staff to perform any and all forms of treatment (including x-rays, study models, photographs or any diagnostic aids), medication, and therapy that may be indicated in the connection with the dental care of the patient above and further authorize and consent to Dr. Maiurano choosing such assistance as she deems fit. I understand that any photographs, diagnostic models, and/or x-rays of my face, jaws and teeth will be used as a record of my care and treatment and further authorize their use for educational and teaching purposes. I understand that all dental procedures and the use of anesthetic agents carry a rare, but real risk. Risks associated with local anesthesia include (but are not limited to) temporary or permanent paresthesia. I understand those risks and have asked any questions that I may have about them, and consent to local anesthesia being administered as part of my dental treatment. I also understand that prior to treatment a full explanation of the procedure(s) involved will be given by Dr. Maiurano and/or staff.

I consent to the use of periodic appointment reminders, phone calls, texts and appointment reminder items sent via U.S mail.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosures of my patient record and agree to release protected health information needed to carry out treatment, payment activities and healthcare operations.

Dental Exposure Policy

I, the undersigned, understand that pursuant to Virginia Code 32.1-45.1, any patient who exposes a health care provider (or employee) to bodily fluid in a manner which may transmit the Human Immunodeficiency Virus (HIV), Hepatitis B or C virus is deemed to have ***consented to HIV, Hepatitis B and C testing***, ***and disclosure of the results to the person exposed***. Conversely, this deemed consent also applies to a health care provider (or employee) who exposes a patient to bodily fluid in the same manner. In the case the above stated condition occurs, I agree to comply fully and immediately with the above referenced Code.

Rescheduling and Cancellation policy

If necessary, I agree to cancel or reschedule any appointment at least 48 “business day” hours prior to my appointment time. If a 48-hour prior notice is not given, a $50.00 non-refundable cancellation fee will be applied. I also agree that being substantially late for an appointment, or missing the appointment, shall be deemed a cancellation and will also subject me to the cancellation fee.

Payment Agreement/Financial Arrangement Policy

In order to maintain a good patient/doctor relationship, an agreement regarding payment options is essential before the start of treatment.

Non-insurance treatments

- Payment due at time of service. Payment may be made with cash, check, or credit card.
- For amounts over $200.00, payments may be divided over a three month period unless other arrangements have been made.

Insurance related treatment

- For patients filing their own insurance, payment is due at time of treatment. Patients will then receive payment from their insurance company.
- For patients who wish our office to submit the claim, co-payments and deductibles will be due at time of treatment. Our office will gladly submit insurances for you. We will wait up to sixty (60) days after your treatment for payment from your insurance company. If insurance has not paid in that time, the entire balance is due from the patient.

We accept the following credit cards: American Express, Discover, Mastercard, and Visa.

Please remember, insurance is an agreement between you and your company. It is your responsibility to pay deductible, coinsurance and any amount not paid by your insurance company.

The signature below is my authorization for the release of information necessary to process my claim. I hereby authorize payment to be made directly to Audrey M. Maiurano, DDS.

Transfer of Patient Records and Digital Media Policy

I understand that any **request to transfer or release** any dental records must be **submitted in writing** due to current HIPAA privacy laws. There is no fee to have records e-mailed to my dentist of choice, however, if paper copies are requested, there is a **fee of $35.00 per family**.

I understand that if I would like a digital copy of my records, I cannot provide my own digital media (e.g. USB storage devices, CDs, and external hard drives). Given the prevalence of computer viruses and other malware that can manifest on these devices especially in hidden form, no devices may be connected to any computer at this office unless it is provided directly by our network administrator. This precaution is taken to protect the computer systems in the office that carry my personal information as well as my patient health records.

Signature

"I have read and understood this entire agreement before signing here below, and I have endorsed this agreement voluntarily, without duress, and of my own free will and choice."

_____	_____	_____
Name of Patient/Representative (please PRINT)	Signature of Patient/Representative	Date