RESTON DENTAL CENTER
Health History and Registration

DATE_____

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____ Would you like to receive dental care reminders via Text Messaging? Yes ____ No ____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT_____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED_____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ PHONE _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have additional dental insurance coverage, complete this for the secondary carrier.

Insured's Name _____

Insurance Co. _____ PHONE_____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENT?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)?	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist?

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now? If yes for what?	☐	☐
Have you ever taken Fen-Phen ☐ Redux ☐ Coumadin ☐		
What MEDICATIONS are you currently taking?		
Do you need to premedicate?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Fainting	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Food allergies	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis (Rheumatism)	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐
Artificial Heart Valves	☐	☐	Heart murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joints	☐	☐	Heart problems (please describe)	☐	☐	Shingles	☐	☐
Asthma	☐	☐	_____			Shortness of breath	☐	☐
Seasonal Allergies	☐	☐	Hemophilia (Abnormal bleeding)	☐	☐	Skin rash	☐	☐
Back Problems	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Blood Disease	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swelling of feet or ankles	☐	☐
Chemotherapy	☐	☐	Kidney disease or malfunction	☐	☐	Thyroid disease or malfunction	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tobacco habit	☐	☐
Cortisone treatments	☐	☐	Material allergies	☐	☐	Tonsillitis	☐	☐
Cough (persistent)	☐	☐	(latex, wool, metal, chemicals)			Tuberculosis	☐	☐
Cough up blood	☐	☐	Mitral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Diabetes	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐
Epilepsy	☐	☐	Pacemaker/heart surgery	☐	☐	Multiple Sclerosis	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin, Local Anesthetic, Erythromycin, Latex (balloons, gloves, etc.), Nitrous Oxide, Codeine, Penicillin

Are you aware of being allergic to any other medications or substances?
If yes, list:

Is there any other Medical or Dental information that you feel we should know about?

FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I and/or my dependent(s), have insurance coverage with_____and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

PATIENT Signature (Parent of Child) _____ **Date:** _____ DENTIST Signature _____

rev1/1/2007

Reston Dental Center / Tysons Dental Design Center /

www.restondentalcenter.com

New Patient Form

Financial Agreement

Reston Dental Center
12359 Sunrise Valley Drive, Suite 250
Reston, VA 20191
Tel: (703) 860-8613 Fax: (703) 860-8615

Tysons Dental Design Center
8150 Leesburg Pike Suite 830
Vienna, VA 22182
Tel: (703) 388-2883

Leesburg Dental Center
161 Fort Evans Rd, NE Suite 220
Leesburg, VA 20176
Tel: (703) 860-8613

Doctor Name: Jason K Hong, DMD

Patient/Responsible Party Information

Name: _____

Address: _____

Social Security Number: _____

I the undersigned hereby agree to pay to the above named doctor all fees due him for services rendered and/or expenses incurred by me, my spouse or any of my children or dependents. **My co-payment, based on insurance benefits (if applicable), is due at the time of treatment.** _____(initial) Acceptable forms of payment are cash, check, and major credit cards. There is also a payment plan called CareCredit, which allows you to start treatment today and spread payments over time. Applying for CareCredit only takes a few minutes and there is no fee to apply.

I understand the payment of my bill is my legal obligation as the patient. All filings of insurance papers and confirmation of eligibility of benefits and /or confirmation of insurance payments to be made by my insurance company are my responsibility. 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 confirmations. **If a balance remains on my account after the insurance company processes my claim, the balance is due immediately. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.** _____(initial)

If my 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 that is or becomes due, plus all court costs, and interest in the amount of one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. I understand and agree that the terms herein are reaffirmed each time services are received. I further agree to pay returned check charges of $35 per returned check.

Undersigned further agrees to pay a charge of $25 per each half hour of reserved appointment time when cancellation/reschedule notice of at least 48 hours is not given.

_____ _____

Patient/Responsible Party Signature Date

New Patient Form

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Reston Dental Center
12359 Sunrise Valley Drive, Suite 250
Reston, VA 20191
Tel: (703) 860-8613 Fax: (703) 860-8615

Tysons Dental Design Center
8150 Leesburg Pike Suite 830
Vienna, VA 22182
Tel: (703) 388-2883

Leesburg Dental Center
161 Fort Evans Rd, NE Suite 220
Leesburg, VA 20176
Tel: (703) 860-8613

Section A: Patient Information

Name: _____
Address: _____
Telephone: _____
Social Security Number: _____

Section B: To the Patient - - Please Read the Following Statement Carefully

Purpose of consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations; i.e., you allow us to communicate with your insurance company, dental laboratories, if applicable to your treatment, as well as other specialty care dentists you may be referred to.

You have the right to read our Notice of Privacy Practices. The policy 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 protected health information.

We reserve the right to change our privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, 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 revision of our Notice, at any time by contacting Terri Novak at 703-860-8613.

SIGNATURE

I, _____, have had full opportunity to read and consider this Consent form. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

If this consent is signed by a personal representative on behalf of the patient (i.e., parent for minor child), complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

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.