Medical History

PATIENT NAME	MEDICAL ALERTS

Preferred Pharmacy location:______________________________

Pharmacy #:______________________________

Have you taken any medication/drugs during the past two years?...Yes No

Are you taking any medications, drugs, or pills now?...Yes No

If yes, please list name and dosage:______________________________

____

Are you aware of having an **allergic reaction/ adverse reaction** to any medication/substance?.............Yes No

If yes, please list:______________________________

Indicate which of the following you have or had in the past. Circle "yes" or "no" – leave none blank

Heart surgery, disease, attack	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	AIDS	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	HIV Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/ Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/ Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc)	Yes	No	Chemotherapy	Yes	No	Nervous./ Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/ Psychological Care	Yes	No

Do you have or have had any disease, condition, or problem not listed?...Yes No

If yes, please list:______________________________

Women: Are you: Pregnant? Yes ____Weeks/Months, No Nursing? Yes No Taking Birth control? Yes No

I understand the above information is necessary to provide dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian signature:______________________________ Date:______________

Notes:

DENTAL HISTORY

Patient Name	Medical Alert

What is the reason for your visit today?________________________

Date of last Dental visit?__________ Last Dental Cleaning?__________Full Mouth X-rays?__________

What was done at your last dental visit?________________________

________________________.

Previous Dentist's name:______________State:______Phone:__________

How often do you brush your teeth?__________ How often do you floss?__________

What other dental aids do you use?________________________

Do you have any dental problems now? Yes No

If yes, please describe:________________________

Circle yes or no		
Have you noticed any mouth odor or bad tastes?	Yes	No
Do you frequently get cold sores/blisters/ other legions?	Yes	No
Do you gums bleed or hurt?	Yes	No
Have your parents experienced gum disease and/or tooth loss?	Yes	No
Have you noticed loose teeth or change in bite?	Yes	No
Does food tend to get caught in between your teeth?...	Yes	No
If yes, what area?		

Have you ever had...		
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Bite adjustment?	Yes	No
Bite plate/ mouth guard?	Yes	No
Serious injury to mouth or head?	Yes	No
If yes, describe:		

Do you...		
Clench or grind while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth?	Yes	No
Bite you fingernails?	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke or chew tobacco?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If yes, what is your biggest concern?		

Have you experienced...		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of the face)?	Yes	No
Difficulty opening or closing mouth?	Yes	No
Difficulty chewing on either side?	Yes	No
Head, neck or shoulder aches?	Yes	No
Sore muscles (neck, shoulder?	Yes	No
Would you like to keep all of your teeth?	Yes	No
Have you ever had an upsetting dental visit?	Yes	No
If yes, please describe:		

Do you have (or had) to use oral sedatives or nitrous oxide (laughing gas) at dental appointments? Yes No

Is there anything else about having dental treatment you would like us to know? Yes No

If yes, please describe:________________________

____

____

____

________________________.

PATIENT INFORMATION

First Name__________________ M.I. ____ Last Name__________________ Nickname__________________

☐ Male ☐ Female D.O.B. ____/____/______ SSN______________________

Address____ # ________ City__________________

State________ Zip Code______________ Home # (___)______________Cell # (____) ______________

E-mail____ Business # (_____)__________________

Employer____ City______________ State________

For appointment reminders I prefer (check all that apply): ☐ text message ☐ email ☐ phone call

FAMILY INFORMATION

Spouse or Parent Name______________________ Birth Date____/____/_____ SSN__________________

Other family members seen by us____

Who may we thank for referring you to our office? ____

EMERGENCY CONTACT

Name__________________________________ Relationship to you__________________________

Home (____)______________ Cell(_____)__________________ Work(____)__________________

INSURANCE INFORMATION - Will we be filing insurance for you today? Yes ☐ No ☐

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Parent **(if Spouse or Parent listed above, skip next section)**

Name of Subscriber__________________________________SSN__________________________

DOB ______/______/__________ Insurance Company__________________________________

Group #______________________ Member ID # __________________________________

ADDITIONALLY

Please present a copy of the card(s) for all benefit companies to receive dental claims. We make every effort to collect all the benefits due you. Please understand, however, that filing insurance on your behalf is a *courtesy* we offer our patients. Ultimately, each patient is responsible for understanding their benefits and remitting payment to our office when your benefits company has failed to make payment. We strive to give the most accurate estimates possible, but it is considered an estimate due to matters not immediately known by our office and may not reflect total co-pay due. Deductibles and co-pays are due at time services are rendered. We thank you for your understanding.

I HAVE READ THE ABOVE AND UNDERSTAND MY RESPONSIBILITY...INITALS________

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying at the time of each visit. Should monthly payment arrangements be necessary, we offer several options.

All payment arrangements must be approved by our office prior to any major services being rendered.

I hereby authorize release of information necessary to process claims and to release payment to this doctor of the benefits otherwise payable to me.

SIGNATURE OF PATIENT/GUARDIAN____

TODAY'S DATE__________________________

DR. RONALD C. FUHRMANN, D.D.S

A division of Atlantic Dental Care
216 Business Park Drive, Suite A
Virginia Beach, VA 23462
757-499-8465

Welcome to the practice of Dr. Ron C. Fuhrmann. In an effort to better acquaint you with our practice, we have outlined the following policies our office upholds.

Office Hours

We are in the office **Monday – Wednesday from 9:00 a.m. – 4:30 p.m** and **Thursday from 9:00 a.m. – 3:30 p.m.** In the event of a dental emergency, please call our office and leave a message as instructed. **Our contact # is: 757-499-8465.**

Financial Policy

For your convenience, we accept cash, checks, money orders and all major credit cards. We also accept CareCredit (a healthcare credit card – please see front desk for details). **Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service.** Returned checks and unpaid balances may be subject to collection placement and collection fees.

Insurance Authorization and Assignment

I authorize Dr. Ronald C. Fuhrmann to furnish information to insurance carriers concerning my dental health. I permit a copy of this authorization to be used in place of the original and request payment of dental insurance benefits to the party that accepts assignment. I understand that I am responsible for any amount not covered by my insurance.

Please note, your insurance policy is a contract between you, your employer, and the insurance. We are NOT a party to the contract. Therefore, we WILL NOT become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances, and "usual and customary" charges. Also, we will not know if your insurance will cover a procedure until the claim(s) has been submitted.

For those with a benefit plan we will be happy to file your dental claim(s); however, **if after 90 days from the date of service your benefit plan has not paid your claim YOU will be expected to pay the balance.**

Past Due Accounts

If there is a balance on your account you will receive a monthly statement reflecting charges which are 30 days, 60 days, or greater than 90 days past due. For all accounts which are 90 days past due, an 18% APR annual finance charge will be assessed at the end of each month. All accounts needing further collection action will be charged all collection costs and legal fees necessary to collect the debt.

Waiver of Confidentiality

I understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if my past due status is reported to a credit reporting agency, the fact that I received treatment at our office may become a matter of public record.

Missed Appointments

Patients who do not show up for an appointment or cancels with **less than 24 hours Notice will be charged a <u>$50.00</u> broken appointment fee.** This fee MUST be paid before a new appointment will be given. Patients with **<u>2</u> missed** appointments may be asked to transfer to another dental practice for future services.

Consent for Treatment

I give authorization to doctor and/or designated staff to take x-rays, study models, or any other diagnostic aids deemed appropriate by Dr. Ronald Fuhrmann to make a thorough diagnosis of my dental needs. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. Also, I consent to fillings without an additional consent form and understand the following: The most common conditions encountered with fillings are pain, sensitivity to temperature or pressure, fractures of teeth or roots, nerve damage, damage to other teeth, occlusal (bite)...

---CONTINUE TO NEXT PAGE---

---CONTINUED OFFICE PROCEDURES/ CONSENT FORM---

discrepancies, temporomandibular joint problems, and occasional allergic reactions to filling materials. Changes in Treatment Plan: During the course of treatment, procedures may need to be added, expanded, or changed if the dentist finds conditions that were not identified during examination and first observed during the course of treatment. The most common scenarios include the need for root canal therapy and more extensive restorative procedures, like crowns, bridges, or implants. Permission is hereby given to perform any additional or expanded dental services that the dentist determines to be necessary. Further, at the dentist's discretion, I may be referred to a specialist for further treatment, the cost of which will be my responsibility.

Personal Information

It is our office policy to require personal information from our patients, including but not limited to social security number, date of birth, and a copy of a photo ID. Not providing this information could lead to refusal of treatment from our office. In the event a patient requests any of their information to be emailed, we will need the patient to first email us at the provided office email in order to verify the identity and satisfy HIPAA requirements.

By signing below, I acknowledge that I have read or have had read to me, have been given a personal copy, I fully understand and agree the above office policies.

Print Patient/Guardian Name:______________________________ **Date:**______________

Signature of Patient/ Guardian:______________________________

HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information (PHI) may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

Below is a list of ways the office may contact you. Checking a box will give permission to leave, as thorough of a message as needed, from your dental office. This will include, but not limited to, appointments day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than the USPS, example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

Please check all that apply, and write in appropriate information needed for contact.

__Work Cell ______________________ __ Personal Cell ______________________

__Work Phone ______________________ __ Home Phone ______________________

__Work Fax ______________________ __ Home Fax ______________________

__ Work Email ______________________ __ Home Email ______________________

__ Mail to Work ______________________ __Mail to Home ______________________

__Emerg. Contact ______________________ __Interpreter Contact ______________________

__ **Any of the above**

List names of who can have access to your dental/medical chart information: Circle Type.

State what part of your chart: Financial, Treatment, Health history, is allowed to be disclosed or copied

______________________ **Full** access / **Partial** access ______________________

______________________ **Full** access / **Partial** access ______________________

_____ Patient gives office permission to forward any verified contact information and PHI to patients specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patients case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

PLEASE SIGN OTHER SIDE

Print Patient's Name: ____ **Date** __________________

Print Legal Guardian's Name: _____________________________________ **Date** __________________

Signature of Patient or Legal Guardian: ______________________________ **Date** __________________

____Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

Office Staff Signature___________________________ **Printed Name**___________________________ **Date** _________

Witnessed Staff Signature________________________ **Printed Name**___________________________ **Date** _________