NOVALINE DENTAL

9822 Liberia Ave Manassas, VA 20110
Tel: 703-659-1944

New Patient Registration Form

Date: ___________________

Patient Name: ____
First Middle Last

Address: ____________________________________ City: ______________ State: ______ Zip: ________

Sex: __ Female ___Male Age: _______ Date of Birth: ___________________ SSN: __________________

Phone (Home):(_____) ______-__________ Cell: (_____) _____-________ Email:___________________

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Spouse's Name: _____________________________________ Date of Birth: ______________________________

Employer: ______________________________________ Occupation: ____________________________________

Work Address: ____ Work Number: ________________________

Emergency Contact Name/Number: ____

How did you hear about us? Referred by: Insurance ☐ Friend/Family Member ☐ Internet ☐

Flyer/Postcard ☐ Walk by ☐ Other (Specify) ____

If referred by healthcare provider, give name of practice: ____

Party Responsible for Payment

First Name: __________________________ Middle: __________________ Last: _____________________

Date of Birth: _________________________ Age: _______________ SSN: _________________________

Employer: _______________________________________ Occupation: _____________________________

Employer Address: ____ Work Number: ____________

Primary Dental Insurance

Insurance Name: ____

I.D Number: _____________________________________ Group Number: _________________

Insurance Company Address: ____

Phone Number: ___________________________________ Policy Holder D.O.B: ______________________

Policy Holder Name: ______________________________ Relationship to Patient: ____________________

Secondary Dental Insurance

Insurance Name: ____

I.D Number: _____________________________________ Group Number: _________________

Insurance Company Address: ____

Phone Number: ___________________________________ Policy Holder D.O.B: ______________________

Policy Holder Name: ______________________________ Relationship to Patient: ____________________

Dental History

Date of last visit to your dentist: ________________________________ Last cleaning date: ____________________

How often do you brush? __________________________________ Do your gums bleed while brushing? Yes or No

Have you had any unpleasant dental experience in the Past? Y or N Do you have a question for the doctor? ____________

____

Have you had any of the following conditions or received treatment for any of these in the past?

☐ Sensitive Teeth ☐ Jaw Pain ☐ Root Canals ☐ Oral Surgery ☐ Orthodontics ☐ Gum Treatment ☐ Implants

☐ Loose Teeth ☐ Injury to Teeth ☐ Veneers ☐ Bridges ☐ Dentures ☐ Whitening ☐ Crowns ☐ Fillings

For your safety, it is important to let your dentist know the medical conditions you are having or are being treated for and the medications that you are taking so as to minimize complications from dental procedures and occurrence of adverse drug reactions. Thank you for answering the following questions:

Are you under the care of a physician's care presently? ◯ Yes ◯ No If yes, please explain: ____________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________

Have you had serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________

Are you taking any medication, pill, or drug? ◯ Yes ◯ No If yes, please explain: ____________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________

Have you ever taken or are you taking Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ____________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

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

☐ Other If yes, please explain: ____________

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Depression	◯ 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 Fatigued	◯ 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	Steroid Treatment	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ 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 Pain	◯ 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 Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Eyes/Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ____________

If you ticked "Yes" to any of the above, please, provide further information below:

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____________________________DATE ____________

Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following information:

- Full payment is due at the time of service unless other arrangements have been made prior to starting your treatment
- We accept **cash**, **major credit cards** (Visa, MasterCard, Discover Card and American Express), debit cards, and Care Credit.
- We will always file to primary insurance then secondary, if any, on file at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Insurance balances are ultimately the patient's obligation. Please keep your walk-out statements and follow up with insurance carrier to ensure prompt payment.
- Some of your treatment may **not** be covered by your insurance. The cost of such services is your responsibility.
- Major services such as crowns, bridges, dentures, etc. may require a deposit equal or at least half of the estimated patient portion at the time of the appointment and paid in full when the work is completed or delivered.
- Patients are asked to confirm their appointments at least 48 hours in advance. If you cancel appointment less than 24hrs or do not show up at your appointment, this may result in a charge of $40.00 per patient.
- Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:
  - Interest charge of 1.5% per month
  - 18% APR collection fee (up to 25% of full balance)
  - Legal fees for collection services
- Please, note that there is **a $30.00 fee** for any check returned as **Non-Sufficient Funds** (NSF).

Privacy Policy

- The information you give us will NOT be given or sold to anyone else for commercial use.
- You can obtain a copy of your treatment record. Parents can have a copy of their children's treatment record.
- You can add information to your medical record especially new medical conditions and treatment.
- Any communication of treatment to other health practitioners (dental specialist, personal physician) or anyone else (insurance company, public health or law enforcement agency, etc.) will be documented in your records.
- You can tell us who you specifically do not want any information discussed with such as a relative, business associate, etc.
- Please tell us if there is something about your treatment or experience that you found objectionable. We can only improve if we receive feedback and suggestions.

Minor/Child Consent

I, being the parent/guardian of ________________________________herby authorize the dental staff to administer treatment and use anesthetics as advised by the doctor. In the case that I am not present at the actual appointment when the treatment is rendered. I will send written consent for any treatment with the person that will be accompany my child to their dental appointment.

Patient name: ______________________________ Signature: ___________________ Date: __________

I confirm that I have read the information above and agree to the office policy

Informed Consent Form for General Dental Procedures

You, the patient have the right to accept or reject dental treatment by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommend procedure, treatment option or alternatives.
Do not consent to treatment unless and until you discuss potential complications with your dentist and your concerns are addressed. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications no matter how slight the probability of occurrence.
As with all surgery, there are known risks and potential complications associated with dental treatment. No one can guarantee, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.
Some of the more commonly known risks and complications of treatment include, but are not limited to the followings;

- Pain, swelling and discomfort after treatment
- Possible injury to the jaw joint and related structures requiring follow-up care and treatment or consultation by dental specialist.
- Temporary or on very rare occasion permanent numbness pain tingling or alternated sensation of the lip, face, chin, gums, tongue along with the possible loss of taste.
- Damage to adjacent teeth, restoration or gums.
- An altered bite in need of adjustment.
- Possible deterioration of your condition which may result in tooth loss
- Jaw fracture
- Allergic reaction to anesthetic or medication
- Root tip bone fragment or a piece of a dental instrument may be left in your body and may have to be removed at a later point in time.
- Upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
- Infection in need of medication, following up procedures or other treatments
- The need for replacement of restorations implants or other appliances in the future.
- Need for follow up care and treatment including surgery
- Prolonged numbness

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication pre and post treatment instructions, referrals to other dentist or specialist, and follow up appointment.
Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or murmur please to report any problem to your dentist immediately so he/she can consult with your physician if necessary.

Patient Name: _____________________________ Signature: _______________________ Date: ___________

This form is intended to provide you with an overview of potential risk and complications. Do not sign this form or agree to treatment until you have read, understood and accepted each paragraph stated above

Patient Consent to Receive Mail, Phone Call Messages, and Email

Patient name: ____

I agree that the practice may communicate with me electronically at the following address:

Phone number: (____) _______-________   Email: ______________________________

Do we have your permission to:

Send a recall appointment reminder to your home?   Yes   No

Leave appointment, billing, or dental information on your answering machine, email? Yes   No

I give permission to share appointment, billing, or dental information with the person listed below:

Name___________________________________ Relationship to patient: ____________

Please sign: ____________________________________ Date: _______________