AVANT DENTISTRY

Patient Name: _____ Today's Date:_____
Last, First MI (Preferred Name)

Email: _____ (*for appointment reminders and helpful dental facts*)

Sex: M F Preferred pronoun:_____ Marital Status: _____ Birth Date: _____ S.S *#:*_____

Phone (Home): _____ (Cell): _____ (Work): _____ Preferred #: (please circle) Home Cell Work

Address: _____
Street Apartment #

_____
City State Zip Code

Preferred Pharmacy:_____ Phone:_____

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Acid Reflux/GERD
- ☐ Allergies _____
- ☐ Anemia
- ☐ Anticoagulants
- ☐ Arthritis
- ☐ Artificial Joints:_____
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Cancer/Chemo/Radiation tx
- ☐ Diabetes:_____
- ☐ Dizziness/Vertigo
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ IV Bisphosphonates
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Migraines
- ☐ Nervous Disorders
- ☐ Oral Bisphosphonates
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Premedication:_____
- ☐ Pregnancy
  Due date:_____
- ☐ Pulmonary Embolism
- ☐ Radiation Treatment
- ☐ Recreational drugs
  Type: _____
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Seizure disorder:_____
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Smoking / Tobacco
  __#packs/day? __Years?
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

☐ _____

Please list any current medications (both prescription & over the counter):_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician & address: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian : _____ Date:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address_____

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Release of Information

In accordance to the HIPAA Privacy Act, please note that for all patients over the age of 18, we are unable to release any information (including but not limited to treatment plan, treatment history, appointment dates, financial information, insurance information, etc.) to anyone (including family members, policy holders, etc.) unless given written authorization. Please list the name(s) of the person(s) you allow us to share your information. If none, please write "none."

Name	Relationship to patient	Phone number
Name	Relationship to patient	Phone number
Name	Relationship to patient	Phone number

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Google ☐ Yelp ☐Facebook ☐ Website ☐ Insurance company ☐Washingtonian Magazine ☐ Other _____

Name of person or office referring you to our practice: _____

Consent for Services

Consent for Services:

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

2. Upon such diagnoses, 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.

3. I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

4. I hereby give Dr. Yu the absolute right and permission to use my photographs/ slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

Cancellation Policy

We, at Avant Dentistry, kindly request 48-hour notice for appointment cancellations and last minute re-scheduling. We never double-book our appointment slots—this allows us to give you the attention and the highest quality of care on which we pride ourselves. We reserve the right to assess a fee, up to 25% of the estimated treatment cost or reservation deposit, on your account. While we understand that unforeseen circumstances may occur, we ask that you please respect the time that we have reserved exclusively for you.

I have read the above conditions (1 through 4) of treatment and policies, and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have reviewed/received a copy of Avant Dentistry's HIPAA Notice of Privacy Practices. If I lose my copy, I am aware that I can request a new copy at any time.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

FINANCIAL POLICY

This statement is to inform you of our financial policy. We at Avant Dentistry, are committed to providing you with the highest quality of dental care, utilizing only the best materials and education available. In our process of doing so, we have formulated a financial policy to continue excellent service to you and minimize our administrative costs.

Payments are due at the time service is provided. For your convenience, we accept cash, check, and most major credit cards (Visa, MasterCard, and Discover). We also accept Care Credit financing (please ask our staff for further details). Returned checks and balances older than sixty (60) days are subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

If you have dental insurance, we welcome most insurance plans, meaning that we will assist you in processing your insurance claims. We will make every effort to maximize your benefits. Your treatment plan however is individually tailored for your specific needs, and not based on your dental insurance benefits. Not all services are covered benefits in all policies. Patients are ultimately responsible for any non-covered services and/or any balance not covered by your insurance policy.

We are a preferred provider for, but not limited to the following plans: GEHA Connection Dental, United Concordia, and Guardian/Careington PPO. Patients are ultimately responsible for knowing the terms of their insurance (i.e. any in-network vs out-of-network benefits, deductibles, co-pays, non-covered services, any balance not covered by your insurance policy, etc.). For all other dental PPO plans, you may still maximize your benefits—we will file all necessary paperwork for you with our fees due at the time services are rendered; your insurance company will then reimburse you directly based upon your plan.

We require a **Reservation Deposit** of 25% of estimated treatment cost for all treatment reservation times—this amount will be applied to your future treatment. **Furthermore, we kindly request that our patients give at least 48-hour notice for all cancellations including last minute re-scheduling to avoid any penalties.** In the event that the appointment was for a routine hygiene appointment **$75** may be charged to the account. If the appointment was for treatment (i.e. crowns, roots canals, restorations, etc.) the fee assessed may be 25% of the appointment's original estimated cost. Please help us better serve you by keeping scheduled appointments.

If you have any questions regarding our financial policy, please do not hesitate to ask. We are committed to providing you with the most positive experience in dental care.

I, _____(*print name)* have read, understand, and agree to adhere to Avant Dentistry's Financial Policy, and by signing, I grant permission for Avant Dentistry to submit claims to my insurance company on my behalf.

Signature: _____ Date: _____

AVANT DENTISTRY

NOTICE OF 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 our 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 5/1/13 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, provided 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 changes. 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 our 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.

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 healthcare, 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 a determination using our professional judgment 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 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 area 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 or 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 $0.73 per page, $1.00 per page copy of individual x-rays and photographs if applicable, $ 0.00 per hour for staff time to 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 April 14, 2003. 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 or 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.

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 also may 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. Annie Yu

Telephone: 240-743-4421 **Fax: 240-483-0728**

E-mail: info@avantdentistry.com

Address: 5454 Wisconsin Ave., Suite 1035, Chevy Chase, MD 20815

AVANT DENTISTRY