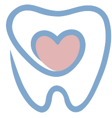


KINGSTOWNE
DENTAL SPECIALISTS

Dr. Robert Marzban

Health History Form

Welcome! We are thrilled you're here!

Patient's Name____ Patient's Date of Birth____/_____/________

Address ____ City________________________ State_____ Zip________

Phone (Home) ______________________ (Cell) Phone______________________ (Work) Phone____________________

Preferred Email____

How Did You Hear About Us? ____

Insurance Information

Insurance Company ____

Insurance Policyholder's Name _______________________________________ Date of Birth____/_____/________

Insurance Policyholder's Address ___________________________City____________________ State_____ Zip________

Patient's Relationship to Policyholder ___________________________________

Insurance Policyholder's Social Security Number __________________________

- **SSN required to check orthodontic insurance benefits**
- **Please give ALL responsible party's insurance cards to the front desk**

Financial Party Information

Responsible Party Name ____ Date of Birth____/_____/________

Relationship to Patient _______________________________________

Phone (Home) ______________________ (Cell) Phone______________________ (Work) Phone____________________

2nd Responsible Party Name (if applicable) _______________________________ Date of Birth____/_____/________

Relationship to Patient _______________________________________

Phone (Home) ______________________ (Cell) Phone______________________ (Work) Phone____________________

Dental History

Name of General Dentist_______________________________________ Location ______________________________

Month of last dental checkup____

Is there any dental work (filling, root canal, crown, extraction, etc.) that you have planned or that needs to be done?

____

Missing teeth? _______________________

Prior orthodontic treatment?	YES	NO
Apprehensive about dental care?	YES	NO
Prior deep cleanings needed?	YES	NO
Prior gum grafts?	YES	NO
Speech problems/therapy?	YES	NO
Thumb/finger sucking (past or current)?	YES	NO
Trauma or accident to face or teeth?	YES	NO

Sleep Apnea History

Mouth breathing?	YES	NO
Snores during sleep?	YES	NO
Sleepy during the day?	YES	NO
Wake up gasping for air?	YES	NO

TMJ History (Jaw Joint)

Do you have TMJ problems?	YES	NO
Grinding or clenching teeth?	YES	NO
Ever worn a night guard?	YES	NO
Frequent headaches in the morning?	YES	NO
Sore jaw or neck muscles?	YES	NO
Bite shifted or changed recently?	YES	NO

Medical History

Requires pre-medication with antibiotics?	YES	NO

List medical conditions:

List medications currently taken:

Any history of:

Radiation Therapy?	YES	NO
Bisphosphonate Therapy?	YES	NO
Hormone Therapy?	YES	NO
Autism?	YES	NO
Sensory Problems?	YES	NO
Growth Problems?	YES	NO
Heart valve replacement?	YES	NO
Diabetes?	YES	NO
Endocrine Problems?	YES	NO
Rheumatoid joint conditions?	YES	NO

Patients Under 18

School____

Sports____

HIPAA PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility.

Please Initial and Sign:

______ In accordance with HIPAA regulations (refer to laminated forms), I understand that this information will be held in strict confidence. I hereby give my permission for the office of Kingstowne Dental Specialists to use patient records for diagnosis, treatment, promotion, and education.

______ I authorize Kingstowne Dental Specialists to release any information necessary for insurance purposes and authorize direct payment of insurance benefits to Dr. Marzban for services rendered.

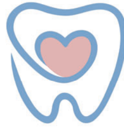
______ I understand the risks of unencrypted email and give my consent for Kingstowne Dental Specialists to use unencrypted email to communicate with me and my dentist regarding personal health information (appointment scheduling, billing & payment, orthodontic care & treatment, X-rays, and emergency questions).

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ____________________________ Relationship: ________________________________

Name: ____________________________ Relationship: ________________________________

Signature of Patient or Responsible Party _______________________________________ Date___________________



KINGSTOWNE
DENTAL SPECIALISTS
5911 Kingstowne Village Pkwy #150
Alexandria, VA 22315
Phone: 703.493.0622
Fax: 703.215.1262

FINANCIAL AGREEMENT

We believe that our Patient Financial Agreement is as important as the services that we perform. It is our responsibility to inform you of charges and our payment guidelines prior to treatment. Determining costs for insured patients is more difficult and less accurate. Your insurance is a contract between your employer and a dental insurance company. Benefits received are based on the terms of the contract negotiated between your employer and the dental insurance company, and not the dental office. The goal of most dental insurance policies is to provide only basic care for specific dental services and typically have little to do with your child's needs or achieving a high-quality, complete result. Many needed services may not be covered. Our office will do everything possible to help you understand and make the most of your dental benefits. As a courtesy, our office will complete and submit your insurance forms to achieve the maximum reimbursement to which you are entitled. **Please remember that you are ultimately responsible for all expenses incurred. We urge you to read your dental insurance policy so that you are fully aware of coverage and any limitations of the benefits provided.** If an exact determination makes you more comfortable, the best method for accuracy is to pre-authorize the procedures with your carrier. We want our patients to be able to comfortably afford dental care. We will gladly discuss our payment options with you before beginning your treatment.

Dr. Marzban and his staff are committed to providing excellent dental care and guiding patients in choosing the best payment option for their needs. We accept cash, personal checks, Visa, MasterCard, American Express, Discover, as well as offer Capital One Health Care Financing (a dental credit card). If paying by check, there will be a charge of $25 for any check that is returned due to insufficient funds. A check returned due to NSF may require a credit card number to be placed on file for future payments.

BROKEN APPOINTMENT POLICY

The time for your dental appointment has been exclusively reserved for you/your child. Without proper notification of your inability to be present for an appointment, some other patient who has been waiting for dental care will not receive the dental care they need because we did not have adequate time to notify them of the available time. Therefore, we are requiring that at least **24 hours** notice be given, as a courtesy to us and to other patients, if your scheduled time is inconvenient. **The Broken Appointment fee will be $75, unless otherwise noted. Also, if you arrive to your appointment ten minutes late we reserve the right to reschedule your appointment.**

The patient and/or responsible party have received, read, and understand the financial agreement and broken appointment policies. The patient and/or responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contracted agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be covered service by third party insurers or payors.

I agree that balances over 45 days be applied to my credit card and that I will be responsible for obtaining insurance reimbursement for any outstanding claims. This consent will remain in effect unless cancelled in writing.

Patient's name:____

Name of parent/guardian (if applicable):______________________________

Signature:_____________________________ Date:_______________________

Credit Card: MC VISA AMEX Discover #___________________ Exp:___________________

Office Witness Signature: _____________________ Date: _______________________

KINGSTOWNE

DENTAL SPECIALISTS

AMERICAN ASSOCIATION ORTHODONTICS HEALTH QUESTIONNAIRE

If you have been exposed to a communicable disease, you may spread the disease to the orthodontist, orthodontic staff, or other patients/parents in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

Have you, your child, or others accompanying you to today's appointment or other recent acquaintances tested positive for or been diagnosed as having COVID-19 or any other communicable disease?

Yes_________ No_________

If yes, when? Date_______________________

Do you, your child, or others accompanying you to today's appointment or other recent acquaintances have:

*A Fever (defined as above 99.6 degrees) Yes_________ No_________

*A Cough? Yes_________ No_________

*Shortness of Breath and/or Trouble Breathing? Yes_________ No_________

*Persistent Pain, Pressure, or Tightness in the Chest? Yes_________ No_________

I understand that if the answer to any of these questions is yes, I will be asked to reschedule today's appointment.

Patient's Name (print):____

____ _________________

Patient/Parent's Signature Date

KINGSTOWNE
DENTAL SPECIALISTS

AMERICAN ASSOCIATION ORTHODONTICS INFORMED CONSENT

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes__________ No__________

Patient's Name (print)____

____ ________________________

Patient/Parent's Signature Date