****************** Patient Information ******************

Name: ____ **Gender:** M F

Last First MI (preferred name)

SS# ____________________ **Birth Date:** ______________ **Family Status:** ____________

E-Mail: ____ **Cell:**__________________________

Home Phone: _________________________________ **Work:** _________________________

Address: ____

Street Apartment #

____

City State Zip code

****************** Health Information ******************

Date of last dental visit: _______________ **Reason for last visit:** ____________________

Please list any allergies: ____

List Current Medications: ____

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

__ Anemia
__ Arthritis
__ Artificial Joints
__ Asthma
__ Autism
__ Blood Disease
__ Cancer
__ Cold Sores
__ Coumadin
__ Cushing's Disease
__ Cystic Fibrosis
__ Diabetes
__ Dizziness
__ Epilepsy
__ Excessive Bleeding
__ Fainting
__ Glaucoma
__ Head Injuries
__ Heart Disease
__ Hepatitis
__ High Blood Pressure
__ HIV
__ Jaundice
__ Kidney Disease
__ Liver Disease
__ Mental Disorders
__ Narcolepsy
__ Nervous Disorders
__ Osteoporosis
__ Pacemaker
__ Radiation Treatment
__ Respiratory Problems
__ Rheumatic Fever
__ Sinus Problems
__ SMOKER
__ Stomach Problems
__ Stroke
__ Tuberculosis
__ Tumors
__ Ulcers
__ Venereal Disease
__ Vertigo

Please list due date if you are pregnant____________________

Have you ever had any complications after dental treatment? YES NO
Have you needed emergency treatment/hospitalization in the last two years? YES NO
Do you have any health problems that need further clarification? YES NO
(if you have answered "YES" to any of the previous questions, please explain on back)

Emergency Contact: ______________________________ **Phone:** ________________

(Please list someone not living with you)

Address: ____

******************** Insurance Information ********************

Primary Insurance: ________________________ **Member ID#** ________________

Subscriber's Name: ________________________ **Birth Date:** ________________

Subscriber's SS # ________________________ **Group #** ________________

Employer: ______________________________ **Phone:** ________________

Address: ____

Is insured a patient? YES NO Patient's relationship to insured: ________________

Do you have a secondary insurance plan? YES NO (if "yes" please list on back)

***************** Consent for Services & Privacy *****************

CONSENT FOR SERVICES: As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients (pt.) for the costs incurred in their care. Financial responsibility on the part of each pt. must be determined before treatment. All emergency dental services, or dental services performed without previous financial arrangements, must be paid for in cash at the time services. Pts who carry dental insurance (ins.) understand that all dental services furnished are charged directly to the pt. & that he/she is personally responsible for payment of all dental services. This office will help prepare the pts ins. forms & assist in making collections from ins. companies & will credit any such collections to the pt's account. However, this dental office cannot render services on the assumption that our charges will be paid by an ins. company. A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged to all accounts exceeding 60 days, unless previously written financial agreements are satisfied. I understand that the fee estimate listed for this dental care, can only be extended for a period of 6 months from the date of the pt's examination. In consideration of the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within 5 days of billing, if credit shall be extended. I further agree, the reasonable value of said services shall be billed unless objected to, by me in writing, within the time of payment thereof. I further agree that a waiver of any breach of time or condition hereunder shall not constitute a waiver of any further term or condition. I further agree to pay all costs & reasonable attorney fees it suit be instituted hereunder. I grant permission to your assignee, to telephone me at home or at my work or to e-mail me, to discuss matters related to this form. I have read the above conditions of treatment & payment & agree to their content.

TO THE PARENT/GUARDIAN: By signing this form, you will consent to our use & disclosure of your protected health information to carry out treatment, payment & healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices (NOPP) before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, & healthcare operations, of the uses & disclosures we may make of your protected health information & of other important matters about your protected health information. A copy of our NOPP accompanies this consent. We encourage you to read it carefully & completely before signing this consent. We reserve the right to change our privacy practices as described in our NOPP. If we change our privacy practices, we will issue a revised NOPP, 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 NOPP, including any revisions at any time by contacting: Bittner Family Dentistry & Orthodontics at 1112 Laskin Road, Suite B Virginia Beach, VA 23451, (757) 425-1335.

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 or assignee 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 & that we may decline to treat you or to continue treating you if you revoke this Consent.

MISSED APPOINTMENT POLICY: We enforce a missed appointment policy to ensure that other patients receive care in a timely manner. Appointments missed or cancelled without 24-hour notice are subject to a cancellation fee of $50 per hour of the scheduled appointment time. Please give at least 48 hours' notice to reschedule an appointment.

I, ____ date: ____________ Relationship to Patient _________________

(Signature of patient, parent or guardian)

____ date:_____________ Relationship to Patient _________________

(Signature of Guarantor of payment)

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

To whom may we thank for referring you to our practice? ___________________________

__ Another Patient __ Friend/Relative __ Newspaper __School __ Work __ Internet

We invite you to participate in our online system, features include: Receiving Text and E-Mail appointment reminders, Confirm appointments via text and e-mail, Refer your friends online, Submit patient satisfactory surveys and Receive occasional promotions.

Please check a source in which you would like to receive appointment reminders:

___ Text _____ E-Mail _____ Phone