BOGACKI & BOGACKI DDS, PC

8344 Traford Lane ~ Springfield, Virginia 22152
office: (703) 451-2867 ~ fax: (703) 991-8448 ~ www.bogackidental.com

Patient Information

Patient Name: _____ Date of Birth: _____
Last First MI

Medical History

Answer all questions by circling either YES or NO and fill in all blank spaces where indicated. Answers to the following questions are for our records only and are confidential.

1.	Are you now under the care of a physician? If so, what is the condition being treated?		
2.	My last medical physical examination was on (approximate date)		
3.	The name & address of my physician is		
4.	Are you taking any drugs or medicines If so, what:	YES	NO
5.	Are you taking any of the following	YES	NO
	a) Antibiotics or sulfa drugs	YES	NO
	b) Anticoagulants (blood thinners)	YES	NO
	c) Medicine for high blood pressure	YES	NO
	d) Cortisone (steroids, including prednisone)	YES	NO
	e) Tranquilizers	YES	NO
	f) Aspirin	YES	NO
	g) Insulin, tolbutamide (Orinase) or similar drug	YES	NO
	h) Digitalis or drug for heart trouble	YES	NO
	i) Nitroglycerin	YES	NO
	j) Antihistamine	YES	NO
	k) Oral contraceptive or other hormonal therapy	YES	NO
	l) Other	YES	NO
6.	Are you allergic or have you reacted adversely to:	YES	NO
	a) Local anesthetics (procaine [Novocaine])	YES	NO
	b) Penicillin or other antibiotics	YES	NO
	c) Sulfa drugs	YES	NO
	d) Aspirin	YES	NO
	e) Codeine or other narcotic	YES	NO
	f) Other	YES	NO
7.	Have you been hospitalized within the past 5 years If so, what was the problem?	YES	NO
8.	Do you have or have you had any of the following diseases or problems:	YES	NO
	a) Rheumatic fever or rheumatic heart disease	YES	NO
	b) Heart abnormalities present since birth	YES	NO
	c) Cardiovascular disease (heart trouble, heart attack, angina, stroke, high blood pressure, heart murmur)	YES	NO
	d) Asthma or hay fever	YES	NO
	e) Hives or a skin rash	YES	NO
	f) Fainting spells or seizures	YES	NO
	g) Diabetes	YES	NO
	h) Hepatitis, jaundice or liver disease	YES	NO
	i) Arthritis or other joint problems	YES	NO
	j) Stomach ulcers	YES	NO
	k) Kidney trouble	YES	NO
	l) Tuberculosis	YES	NO
	m) Do you have a persistent cough or cough up blood	YES	NO
	n) Venereal disease	YES	NO
	o) Other (list)		

9. Do you have any blood disorders such as anemia, including sickle cell anemia	YES	NO
10. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma	YES	NO
a) Do you bruise easily	YES	NO
b) Have you ever required a blood transfusion	YES	NO
c) If so, explain the circumstances		
11. Have you had surgery or radiation treatment for a tumor, cancer, or other condition of your head or neck	YES	NO
12. Have you had any serious trouble associated with any previous dental treatment If so, explain	YES	NO
13. Do you have any disease, condition, or problem not listed above that you think I should know about If so, explain	YES	NO
14. Do you smoke cigarettes or use other tobacco products? If yes, how many packs per day?	YES	NO
15. Do you drink alcohol? If yes, how much per day?	YES	NO
Women: 16. Are you Pregnant or have you recently missed a menstrual period	YES	NO
17. Are you presently breast-feeding	YES	NO

Chief dental complaint (Why did you come to the office today?):

Smile Evaluation

Please Rate the following from 1 to 10 with 10 being the highest

How would you rate your current dental health?	1 2 3 4 5 6 7 8 9 10
What would you like your dental health to be?	1 2 3 4 5 6 7 8 9 10
How important is your dental health to you?	1 2 3 4 5 6 7 8 9 10
How would you rate your smile?	1 2 3 4 5 6 7 8 9 10

If I could change my smile I would make my teeth *(Circle Choices):*

-Whiter -Straighter -Close Space -Replace Silver Fillings -Repair Chipped Teeth

-Replace missing Teeth -Replace crowns and caps -Nothing, I like my teeth!

Velscope Oral Cancer Screening

Our practice is continually looking for advances to ensure that we are providing the optimum level of oral care to our patients. We are concerned about oral cancer and look for it in every patient. **One American dies every hour from oral cancer.** Late detection is the primary cause that both incidence and mortality rates of oral cancer continue to increase. As with most cancers, there are primary risk factors: Age, tobacco and alcohol use are major predisposing factors. Studies also suggest that human papillomavirus (HPV) plays a role in more than 20% of oral cancer cases.

We have recently incorporated **Velscope Lesion Detection** onto our cancer screening standard of care. Using Velscope improves our ability to identify suspicious areas at their earliest stages. Velscope, used alongside a doctor's visual exam, is similar to other proven early cancer detection procedures such as the mammogram, Pap smear, and the PSA test. The procedure is painless and gives the best chance to find abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life.

☐ **Accept** ☐ **Decline**

All given information is correct to the best of my knowledge

Signature _____ Date _____

Patient Information

To Front Desk

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

E-mail Address: _____ May we contact you by e-mail ☐ Yes ☐ No

Address: _____
Street Apartment #

_____
City State Zip Code

_____
How did you hear about us?

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

Insurance Information

Primary

Name of Insured: _____
Last First MI

Insurance Plan Name: _____

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

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

Secondary

Name of Insured: _____
Last First MI

Insurance Plan Name: _____

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

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

Authorizations and Consent for Services

To Front Desk

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for 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 five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

AUTHORIZATIONS: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Bogacki & Bogacki, DDS PC.

I have read the above conditions of treatment and payment, and authorizations, 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

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name:

Address:

Telephone: E-mail:

Patient #: Social Security #:

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, 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 Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Dr. Russell E. Bogacki 8344 Traford Lane (703)451-2867

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 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, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

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

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Acknowledgement of Receipt

Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement that you have been notified that our ***NOTICE OF PRACTICE POLICIES*** can be obtained via our office. This document is printable via the web-site for your records.

HIPAA web-site:**http://www.**hhs**.gov/ocr/hipaa/finalreg.html**

- **You May Refuse to Sign This Acknowledgement***

I, _____ , have received acknowledgement of this office's Notice of Privacy Practices.

_____ Date_____

Signature

For Office Use

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

BOGACKI & BOGACKI DDS, PC

Cancellation and No Show Policy

All of the appointments we make require the doctor's or hygienist's undivided attention. When appointments are broken without sufficient notice, it is difficult or impossible to fill the appointment time. Therefore, we need at least 48 hours notice if you choose to reschedule your appointment. **These 48 hours do not include Saturday or Sunday.**

If you do not show up for your appointment, or if you need to reschedule the appointment at the last minute, you will be charged a **$90.00 fee** for each hour, or part of an hour, that is scheduled.

If this happens 3 times, it is our policy, and in your best interest, to end your relationship with this practice.

By signing this I agree to this policy and will pay the fee as explained above. I also understand that this policy applies to anyone that I am making appointments for.

Signature of patient, parent or guardian Date

Please print name

BOGACKI & BOGACKI DDS, PC

FINANCIAL AGREEMENT

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment. You will be asked to review this document once each year.

OPTIONAL PAYMENT TERMS:

_____**Full Payment Discount:** We offer a **10% accounting courtesy** for all treatment exceeding **$500.00** that is paid in full (including expected insurance portion) with cash or credit card at the time of service. We will still file your insurance and the payment will go directly to the subscriber.

_____**Major Services – Two Payment Option:** We offer a two-payment option for crowns, bridges, and denture treatment. One-half of your co-payment is expected at the first appointment and the second half at the seat date appointment.

_____**Care Credit Healthcard – Interest free financing for 6,12,18 or 24 months** depending on proposed treatment plan costs. Ask us for more details.

REGARDING INSURANCE:

We may accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information.

_____Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

_____As part of the financial arrangement process, we will **estimate** what your insurance company will pay. We very much appreciate payment of your uninsured portion upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 30 days.

PAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED. WE ACCEPT CASH, DEBIT CARDS AND CREDIT CARDS (EXCEPT AMERICAN EXPRESS).

Thank you for reading our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand, accept and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date