MODERN ORTHODONTICS
Dr. Nick Mollov
10298 Bristow Center Drive
Bristow, VA, 20136
703-436-0006

PATIENT INFORMATION DATE:_____

Patient's Name: _____Name you prefer to be called: _____ DOB: ____/____/_____

Address: _____City: _____ State: _____ Zip: _____Home Phone: _____

RESPONSIBLE PARTY

Name: _____ Relationship to patient: _____[leave blank if information same as above]

Address: _____City: _____ State: _____ Zip: _____Home Phone: _____

Work Phone: _____ Cell Phone: _____ E-mail: _____ S.S #: _____

Best Number and Time to Reach You: _____Place of Employment: _____

Occupation: _____ Business Address: _____

Spouse: Name: _____ Work: _____ Emergency Contact Number: _____

Name of your general Dentist: _____

Have you had any previous Orthodontic consultations or treatment? : _____

Whom may we thank for referring you to our office? : _____

INSURANCE: Please complete so we may assist you in receiving your insurance benefits

Employee: _____ Relationship to patient: _____

DOB of Employee: _____ S.S. # _____ Employer: _____

Primary Carrier: _____ Claim Mailing Address: _____

Carrier Phone Number: _____ Group # _____ ID # _____

PATIENT DENTAL HEALTH: Please Check one: ___ Excellent ____ Good ____ Fair ____ Poor

What Would You Change About Patient's Smile? _____

_____

Do you wish to talk to a doctor privately about any problem? _____ Yes _____ No

I will allow Modern Orthodontics to photograph and use for educational purposes any aspect of my/ the patient's dental conditions or treatment procedures, and further will allow his/her permission to discuss my condition with my physician and to request information from him.

Patient, or Parent or Legal Guardian signature Date

Modern Orthodontics Medical & Dental Health History

Date: _____

Parent / Guardian Name: _____

Patient Name: _____ **Age:** _____

Is the patient: _____ **Male** _____ **Female**

What are the patients or parents primary concern?

_____Crowding _____Spaces _____ Ringing/stuffiness in ea _____Prominent Jaw
_____Overbite _____Mouth too small _____ Neck pain _____Gummy smile
_____Receding Jaw _____Clicking Jaw _____ Jaw Pain _____Missing teeth
_____Headaches _____Irregularly shaped teeth _____Buck Teeth
_____ Crossbite

Do any other family members have similar conditions Yes _____ No _____

Medical/ Dental History **Present - Physical Health** Good _____ Fair _____ Poor _____
Mental Health Good _____ Fair _____ Poor _____

If a child: Has the patient reached puberty? Yes _____ No _____

Do you currently take any of the following medications:

_____Heart Pills _____Antibiotics _____ Vitamins _____ Birth Control Pills
_____Diet Pills _____Pain Pills _____ Insulin _____ Muscle Relaxants
_____Sleeping Pills _____Rx. for bone disease or cancer Other _____

Have you ever taken, or are you taking, any of the following medications: Aredia (pamidronate), Zometa (zolendrinic acid)
Actonel (risendronate), Fosamax (alendronate) Yes _____ No _____

Has the patient ever had any of the following conditions?

_____Allergies _____ Bone Disorders _____ Dizziness _____Hepatitis
_____Asthma _____ Endocrine Problems _____ Cancer _____Blood Disease
_____Arteriosclerosis _____ Emotional Problems _____ Diabetes _____Heart Disease
_____AIDS _____ Kidney Problems _____ Epilepsy _____Ringing of Ears
_____High Blood Pressure _____ Rheumatic Fever _____ Autoimmune Disorder
_____Low Blood Pressure _____Osteoporosis

Any Allergies to Medications/Food

_____Antibiotics _____Dyes in Food _____ Wheat Products _____Dairy Products
_____Pain Pills _____Nuts _____ **Are you Allergic to Latex?**

The following is also of interest to the Orthodontist / Does the patient exhibit any of the following habits:

Do you?

_____Snore/grind while sleeping _____ Thumb sucking _____ Have pain / clicking in the jaw joint
_____Breathe through the mouth _____ Finger sucking _____ Have difficulty chewing
_____Drink more than 1 glass of milk a d _____ Lip biting or sucking _____ Have speech problems
_____Have frequent colds or sore throat _____ Tongue thrusting _____ Grinding of teeth
_____Have difficulty swallowing _____ Smoking

Other _____ _____

Current General Dentist: _____/ **Office Location** _____

How often do you visit your dentist? Circle **1x yr** _____ **2x yr** **As needed** **Never**

Are you aware of any orthodontic problems? Yes _____ No _____
Has this consultation been requested by: Patient _____ Parent _____ Dentist _____
Have you had any previous consultations or treatment? Yes _____ No _____
Any unusual dental experiences? Yes _____ No _____ Explain: _____
Are there any Medical or Dental problems not listed above? Yes _____ No _____
Do you have any other family members being treated in our clinic? Yes _____ No _____

Additional comments : _____ _____
_____

Patient / Guardian Signature: _____ **Date:** _____

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HIPAA Privacy Practices

It is the policy of our practice that all Doctors and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its Doctors and staff have the necessary medical, dental and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its Doctors and staff for purposes of treatment, payment and dental/orthodontic care operations. To that end, our practice and its Doctors and staff will...

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its Doctors and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its Doctors and staff will
    - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its Doctors and staff respect the patient's individual dignity at all times. Our practice and its Doctors and staff will respect patient's privacy to the extent consistent with providing the highest quality orthodontic care possible and with the efficient administration of the practice.

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- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its Doctors and staff will:
    - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
    - Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.
- Recognize that, although our practice "owns" the clinical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its Doctors and staff will…
    - Permit patients access to their clinical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
    - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their clinical records in accordance with the law and professional standards.
- All Doctors and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All Doctors and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

If you would like a copy of this policy one will be provided for you.

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Acknowledgement of Receipt of HIPPA

Notice of Privacy Practices.

The following signature acknowledges that I have read and understand my privacy rights concerning the use and disclosure of my protected health information as defined under the Health Insurance and Portability & Accountability Act ("HIPPA").

_____ _____

Signature Date

_____

Printed Name

_____

Relationship to Patient

FINANCIAL AGREEMENT

Patient / Parents / Guardian Name _____
Date_____

Orthodontic treatment is an excellent investment in an individual's medical and psychological wellbeing. Financial considerations should not be an obstacle to obtaining health service. If your insurance company rejects a claim and refuse's to pay for a service, it is not a reflection of how important the service is.

Please note our agreement is with you, NOT your insurance company. If your insurance company refuses to pay or pays less than estimated, you must remember that dental insurance is designed to offset the costs of your dental treatment. You are responsible for the cost of your treatment and any insurance reimbursement conflicts. Our office staff will help you to the best of our ability to obtain your maximum benefits. *We strongly advise you, as our patient, to familiarize yourself with your dental coverage and benefits.*

We are providing the following payment options, being sensitive to the fact that different people have different needs in fulfilling their financial obligations.

1. We accept Check, Cash, Visa, MasterCard , Discover, American Express and CareCredit.
2. In-office contract with an extended payment plan, *interest free*.
3. We offer a 3% discount for payment in full. (*Only includes full comprehensive orthodontic treatment) Discount not offered towards limited treatment / retainers/ or replacement retainers)*
4. Please note: Our office has a 24 hour cancellation policy. Your appointment is time reserved especially for you as our patient to provide you with outstanding care for your dental care needs. We strive to provide you with outstanding care for your dental care needs. We strive to provide you with a two day courtesy reminder via e-mail or call; however it is ultimately your responsibility to remember your dental appointment. All accounts over 90 days will be notified in writing of their account being transferred to a collection agency.

Patient's / Guardian's Signature: _____

Date: _____