Mill Dam Dental Care
Dr. Jeffrey R. Leidy D.M.D., M.A.G.D.

1301 First Colonial Road, Suite 101, Virginia Beach, VA 23454
Telephone: (757) 463-1500 www.milldamdentalcom Fax: (757) 463-8727

PERSONAL HISTORY

Patient Name: _____ Birth Date: _____ SSN: _____

Street Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Name/Nickname: _____ Email address: _____

Martial Status: _____Single _____Married _____Separated _____Divorced _____Child _____Other

*IF PATIENT IS UNDER 18 YEARS OF AGE:

Person Responsible for Account: _____ Relationship to Patient: _____

Address (if different from above): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Birth Date: _____ SSN: _____

Do you have **dental** insurance? _____ Yes _____ No

Dental Insurance Company Name: _____ Insurance Phone: _____

Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____

Group/Employer Name: _____ Group #: _____ SSN/ID #: _____

Do you have **secondary dental** insurance? _____ Yes _____ No

Dental Insurance Company Name: _____ Insurance Phone: _____

Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____

Group/Employer Name: _____ Group #: _____ SSN/ID #: _____

What is the reason for your visit today? _____ Does dental treatment make you nervous? _____

Are you in pain now? _____ Date of your last dental visit: _____

Do you snore or feel tired during the day?	Yes	No
Do you have frequent headaches or TMJ symptoms?	Yes	No
Would you like to improve your smile?	Yes	No
Would you like to replace teeth you are missing?	Yes	No

HEALTH HISTORY

Do you now have, or have had, any of the following conditions or diseases? Check all that apply:

_____ADD/ADHD
_____Alzheimer's Disease
_____Anemia
_____Arthritis
_____Artificial Joints
(Joint Type: _____)
_____Asthma
_____Autism
_____Benzodiazepines
_____Biphosphate Compounds
_____Birth Defects
_____Blood Disease
_____Blood Thinners
_____Breastfeeding Now
_____Cancer
_____Diabetes *(***Type***: _____)
_____Drug/Substance Abuse
_____Eating Disorder
_____Epilepsy
_____Fainting/Dizziness
_____Heart Attack
_____Heart Disease
_____Heart Murmur
_____Heart Surgery
_____Hepatitis
_____High Blood Pressure
_____HIV/AIDS
_____Jaw Pain
_____Kidney Disease
_____Liver Disease
_____MR/DD
_____Nervous Disorders
_____Organ Transplant
(Organ Type: _____)
_____Oral Cancer
_____Pacemaker
_____Pregnant Now
(Due Date: _____)
_____Psychiatric Care
_____Radiation/Chemo
_____Respiratory Problems
_____Retinal Surgery
(Date: _____)
(Procedure:_____)
_____Rheumatic Fever
_____Scarlet Fever
_____Seasonal Allergies
_____Sensitivity to Metals
_____Sinus Problems
_____Stomach Problems
_____Stroke
_____Taking Birth Control
_____Tobacco Use
_____Used Fen-Phen
_____Venereal Disease
_____Other
(Please specify:_____)

Previous Surgeries ***(Type & Date)***: _____

Received Antibiotics Prior to Dental Treatment in the Past ***(if yes, why?)***: _____

Are you allergic to any medications? ***Circle One:*** **NO** **YES** ***(if yes, please list)*** _____

_____

Please list **ANY and ALL medications** you are now taking and why you are taking them**:** _____

_____

Please list **ANY and ALL Herbal Supplements** : _____

Please provide: Height:_____ Weight: _____ Do you have a family history of Diabetes? _____

Do you fatigue easily? _____ Do you heal slowly? _____Do you have frequent infections? _____

PCP Name (Medical Doctor):_____ PCP Phone:_____

Emergency Contact:_____ Phone:_____ Relationship to Patient:_____

To the best of my knowledge, all preceding answers are true and correct. I also agree to notify the office immediately of any changes in the above information.

I hereby apply for treatment by the above dentists, their associates, assistants and/or staff. Treatment may include X-Rays, injections, and/or such office procedures deemed necessary, and, I accept the risks and complications associated with such procedures.

I authorize the release and use of dental records gathered by his office as they deem necessary, including study models, photographs and radiographs. I also authorize the release of information necessary for filing any dental insurance; and direct payments to the office for any amounts due on my claim under the stated policies or any other policy I may be asked to be filed. I have given a notice of privacy practices for this office and agree to all information contained within.

I understand that a parent or adult guardian must accompany my minor child and stay in the office until their dental treatment is completed.

Signature:_____ **Date**:_____

As a courtesy to our patients, we will file dental insurance claims to the companies with whom we participate with on your behalf. However, we need to inform you of our financial policy that states if the reimbursement is not received within forty-five (45) calendar days, from the date of treatment, the entire cost of the treatment becomes the responsibility of the patient or the person designated as the guarantor. If you are a patient who has dental insurance with a company with whom we do not participate, we will give you an estimate of the cost for your dental treatment, but you are also responsible for anything not covered by your insurance. **It is important that you understand that any insurance policy you have is an agreement between you and the company and we cannot get involved in any dispute, conflict, interpretation or any other insurance related problem. I understand that this office is NOT a Medicare provider and will not file claims with Medicare on my behalf. I also understand that I do not have authorization to file claims with Medicare for services rendered in this office.**

All patients who subscribe to a DHMO insurance plan will be required to pay any and all co-payments in full at the time of service.

I understand that the office may send appointment reminders and other pertinent and relevant information regarding my dental health to me via voice, text, or email. I agree that these contacts are for my information, consideration, and the benefit of my dental health and are not unapproved solicitations or advertising.

If you are a patient who will be undergoing sedation dentistry, please be advised that sleep dentistry is a very new procedure that is not yet recognized for reimbursement by insurance companies in the General Dentist office. Therefore, payment for sedation is the responsibility of the patient or guarantor and must be paid in full prior to treatment being rendered. Although sedation will not be covered, your insurance company will reimburse you for any benefits that they do allow under your individual plan.

I agree to be financially responsible for the cost of all services rendered to the patient by this office, and, I understand that if payment is not made when due, I agree to pay interest on the balance at 1.5% monthly (18% annually). In the event legal action results in this going to court, I agree to pay attorney fees equal to 40% of the total amount due, plus all allowable court costs. I agree to pay $50 for any returned checks, in addition to the other terms set forth in the above paragraphs.

I am aware that I am responsible for payment for all services rendered if there is an insurance dispute, refusal to pay, or, if payment is not received from my insurance company within 45 days of treatment. For value received, I guarantee the payment terms as set forth above.

SEDATION APPOINTMENTS

The amount of time scheduled for sedation appointments is an estimate. If the sedation appointment time runs over the amount estimated you will not be charged for the additional time; likewise, if the sedation appointment time runs less than we estimated, a refund will not be issued. When scheduling sedation appointments, 25% of the total amount of treatment is required at time of scheduling to reserve the appointment date and time. If you miss your appointment or cancel without giving two (2) business days notice, your down payment will not be refunded.

APPOINTMENT POLICY

We respect the importance of your time and we work very hard to schedule appointments that accommodate the busy needs of all our patients. In return, we ask that our patients make every effort not to change reserved dental appointments. Broken or missed appointments create scheduling problems for other patients and our dental practice as well. With this in mind, we reserve the right to charge for missed or broken appointments without two (2) business days notice. Patients arriving more than ten (10) minutes past their appointed time will be rescheduled.

I understand and agree to the terms set forth above regarding insurance, financial responsibility, sedation appointments and appointment policies.

GUARANTOR SIGNATURE: _____ **DATE**: _____

Consent for Testing

In order to comply with the Occupational Safety & Health Administration Bloodbourne Pathogen Regulation (OSHA), we are requesting your consent to submit to testing of your blood for bloodbourne pathogens (Hepatitis B, Hepatitis C, or HIV/AIDS) **if an exposure occurs** (needlestick injury, blood spatter) to one of the staff. Testing will be done at no cost to you. All information regarding an exposure is confidential.

Signature:_____ Date:_____

Privacy Statement

In order to comply with the new privacy rules governing the sharing of medical information for billing purposes, we need your permission to do the following. Please sign this form to allow for the billing of insurance for your care. **Please mark the appropriate blocks for additional permissions.**

- □ **May leave messages on my voicemail/answering machine**
- □ **May fax information to my fax number**
- □ **May email information to my email address**
- □ **May text information to my cell phone number**
- □ **May share information with the following individuals**

  List Names and Relationship below:

- □ _____
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____

Signature:_____ Date:_____

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HIPAA PRIVACY OF PATIENT HEALTH CARE INFORMATION

Because there can be questions of privacy when health care information is transmitted electronically, Congress has established an all-inclusive sweeping privacy law called the Health Insurance Portability and Accountability Act (HIPAA) to be administered by the Department of Health and Human Services. The Act established standards for health care providers in obtaining and disclosing your personal health information.

Although such information exchange has been routine in the past, and even though we have never had a problem, the law mandates that you must now give specific written consent to continue these traditional communications relating to your personal health information in order to plan and accomplish optimum treatment, to convey and receive pertinent health information and to facilitate payment.

We fully respect the privacy of your dental/medical records, and will continue to do all we can to make them secure and to protect their confidentiality. In order to provide the best possible health care and/or help third parties involved with payment of your account we routinely share and request pertinent health information only with your other medical or dental caregivers, with other concerned parties such as relatives and with others involved in account payment such as insurers, etc. We may from time to time need to confirm or discuss appointments or to discuss care related concerns on your home answering machine, cell phone voicemail or directly to those answering your home or cell phone or to phone callers identifying themselves as a relative or concerned party.

In the course of your treatment we sometimes have to disclose or receive your personal health information from other treatment related facilities (such as laboratories, sleep clinics, pathologists and radiographs) that might not be required to obtain your consent to release to us products or reports relating to your personal health.

HIPAA allows you to consent or refuse to the use or disclosure of your personal health information as described above, but consent or refusal must be in writing. HIPAA does recognize the necessity of information exchange for optimum patient care, and it has provided for denial of treatment if you choose not to consent. If you choose to give consent by signing this document, you have the future right to revoke or restrict part or all of this Personal Health Care Information Agreement, but you may not revoke or restrict actions that have already been taken that relied on this or a previously signed consent. Of course you personally have the right at any time to access any information we have in you personal health records. Your signature below indicates your consent.

Please ask for our Privacy Coordinator if you have any questions concerning this form or if you desire to review a full copy of our Notice of Privacy Practices.

If you think we may have violated your privacy rights, contact our Privacy Coordinator. You may also 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. We will not retaliate in any way if you choose to file a complaint.

_____ _____

Signature ***(Patient or Parent/Guardian if Patient is a Minor)*** **Date**

_____ _____ _____

Printed Name of Signer **Patient's Name** **Patient's Date of Birth**

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Consent/Release Form for Dental Photography & Social Media

For News Media, Social Media, Promotional Materials, Written Articles, Education, Research, Photographs and/or Videos

I, _____ (Patient Name Printed), **authorize:**

Dr. Jeffrey R. Leidy and his respective employees and/or agents to take photographs, and/or videos of my face, jaw and teeth, before, during and after treatment.

I consent to allow the photographs and/or videos to be used for the following:

□ Dental Records
□ Dental Research
□ Dental Education including lectures, seminars, demonstrations, professional publications such a journals or books
□ Marketing material including websites, social media, printed materials and patient education

I prefer that:

□ My complete name be used

□ My first name only be used

□ No name be used

♦ ***(all other identifying information will be kept confidential)*** ♦

□ Check here if you do not want your full face shot used for any of the above purposes

My consent is given freely and I do not expect compensation, financial or otherwise, for the use of these photographs and/or videos.

I release Dr. Jeffrey R. Leidy and his respective employees and/or agents from any and all liability which may arise from the use of such news media stories, online social media stories, promotional materials, written articles, patient education, research, photographs and/or videos.

I understand that I can revoke this release any time in writing and that the use of my photos/videos or other information authorized by this release will immediately cease.

Please print or type:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Signature: _____ Date: _____

The signature of a parent or legal guardian is required if the above individual is under the age of 18 or is not competent

☐ **Check here to decline**

Urbanek TMJ Splint Health Questionnaire

Dr. Leidy is the exclusive licensed provider of the Urbanek splint in the greater Hampton Roads area, which is a device designed and patented by Dr. Urbanek to reduce inflammation in and around the temporomandibular joint (TMJ). Reduction of inflammation in and around the joint can help reduce a variety of symptoms, including frequent severe headaches, earaches, fullness in the ears, ringing, dizziness/vertigo, pain which radiates down the back/sides of the neck, or forward into the jaw, shoulder or arm pain and/or tightness, and tingling or numbness in the arms, hands, or fingers. As a courtesy to our patients, we include this Health Questionnaire to determine if the Urbanek Splint would be of benefit to you.

Please respond to each positive question by writing in "**YES"** or circling the question:

1. **Do you have frequent or recurring headaches?**
2. **Do you have frequent or recurring earaches?**
3. **Do you have any pain that goes down the back of the neck, to the side of the neck, or forward into the jaw?**
4. **Do you have any problem with ringing in your ears?**
5. **Do you have any fullness in your ears, like you've been swimming and can't clear your ears?**
6. **Do you have any problems with dizziness/vertigo?**
7. **Do you have any problem with shoulder or arm pain, or shoulder or arm tightness?**
8. **Do you have any problem with arm, hand, or finger tingling or numbness?**
9. **Does your jaw ever lock, where you go to open and you couldn't open all the way, felt like it was catching, caught, or couldn't fully open?**

If you responded "Yes" to any of the questions above, please list the names of any and all health care providers you have seen over the years to address these symptoms, including primary care physicians, PA's, NP's, ENT's, allergists, neurologists, physical therapists, chiropractors, massage therapists and/or acupuncturists:

_____

_____

_____

PATIENT SIGNATURE: _____**DATE**:_____

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SURVEY

How Did You Hear About Us?

- □ Search Engine (Google, Yahoo, etc.)
- □ Social Media
- □ Blog or Publication
- □ Driving By
- □ Referral (Family/ Friend)
- □ Referral (Doctor)
- □ Other _____