TIME 08:12 AM

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 8:12 AM

Stone Springs Dentistry

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Question	Answer	
Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:__________

STONE SPRINGS
DENTISTRY

Nikta Marvdashti D.M.D.
24600 Millstream Drive #480
Aldie, VA, 20105
(703)327-7222

Appointment and Financial Policy

Our goal is to provide quality individualized dental care in a timely manner. We are committed to fully informing every patient every time of their financial responsibility prior to treatment.

Cancellation and No-Show

Please be mindful of other patients' needs and notify us at least 24 hours in advance. No-Show will be recorded in your chart including late arrivals (arriving after 15+ min).

- 1st occurrence of tardiness, last minute cancellation, and no-show will result in warning.
- 2nd occurrence will results in a fee of $50.00
- 3rd occurrence will be the fee of the visit.

Please call our office to cancel or reschedule your appointment. If you are unable to reach us you may leave a detailed message with your name and phone number.

You are responsible for the cost of the treatment provided in our office. We work with you to understand your anticipated benefits; however, you are responsible for any costs not paid by insurance.

- Any benefits obtained by our office on your behalf are an *estimate*. Your insurance is a contract between either you or the employer and makes the final payment decision.
- If you have concerns about services exceeding $500, you may request a pre-authorization to be submitted.
- Insurance fees vary commonly due to exclusions or deductible and policy maximums. The patient is responsible for the requested payment if the insurance does not cover a rendered service.

Your payment to our office is due on the day of service.
The full amount of payment is due for treatments completed in a single appointment. For treatments that require *multiple* appointments, we will inform you of the payment amount that is due at each appointment.

____________________________ ____________________

Patient's Signature Date

STONE SPRINGS
DENTISTRY

Nikta Marvdashti D.M.D.
24600 Millstream Drive #480
Aldie, VA, 20105
(703)327-7222

HIPAA CONSENT FORM

Patient Name:______________________

Patient phone: ______________________

HIPAA-Notice of privacy practice
HIPAA is a federal law developed to provide a standard for the protection of your health Information. The purpose of the Notice of privacy practice is to explain how Stone Springs Dentistry may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Stone Springs Dentistry has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA privacy rule to distribute this notice to you and obtain acknowledgement that you have received the Notice. Signing below indicates that you have received the Notice of privacy practice.

I hereby acknowledge that I have received a copy of Stone Springs Dentistry Notice of Privacy Practices.

____
Initials of patient/guardian

Permission to Share Medical/Dental information

My medical information may be obtained and exchanged verbally to :______________________
Name/Relationship

____
Initials of patient/guardian

Dental treatment plan and recommendations may be mailed to my home address.

____
Initials of patient/guardian

STONE SPRINGS DENTISTRY

Last	First	Middle Initial	Neck Size +2 Male ≥ 16.5 +2 Female ≥ 15.0 **Score** ☐
DOB	Male ◯ Female ◯	ID # optional	
Height _______ ft. _______ in.	Weight _______ lbs.	Neck Size _______ in.	

High Blood Pressure	◯ Yes	◯ No	Stroke	◯ Yes	◯ No	+1 for each Yes response ☐
Heart Disease	◯ Yes	◯ No	Depression	◯ Yes	◯ No	
Diabetes	◯ Yes	◯ No	Sleep Apnea	◯ Yes	◯ No	

Lung Disease	◯ Yes	◯ No	Nasal oxygen use	◯ Yes	◯ No	Do not assign any points to these eight responses
Insomnia	◯ Yes	◯ No	Restless leg syndrome	◯ Yes	◯ No	
Narcolepsy	◯ Yes	◯ No	Morning headaches	◯ Yes	◯ No	
Sleep Medication	◯ Yes	◯ No	Pain medication	◯ Yes	◯ No	

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
sitting and reading	◯	◯	◯	◯
watching tv	◯	◯	◯	◯
sitting inactive in a public place (i.e., theater, meeting)	◯	◯	◯	◯
as a passenger in a car for an hour without a break	◯	◯	◯	◯
lying down to rest in the afternoon when circumstances permit	◯	◯	◯	◯
sitting and talking to someone	◯	◯	◯	◯
sitting quietly after a lunch without alcohol	◯	◯	◯	◯
in a car, while stopped for a few minutes in traffic	◯	◯	◯	◯

Epworth Score TOTAL the values from all 8 questions.

If: 11 ≥ Score = 0.

If: 12 ≤ Score = 2.

Score ☐

ESS = _____ / 24

Frequency **0 – 1 times/week** **1 – 2 times/week** **3 – 4 times/week** **5-7 times/week**

Assign points for each of the first three responses.

On average in the past month, how often have you snored or been told that you snored?
never ◯ rarely ◯ + 1 sometimes ◯ + 2 frequently ◯ + 3 almost always ◯ + 4 ☐

Do you wake up choking or gasping?
never ◯ rarely ◯ + 1 sometimes ◯ + 2 frequently ◯ + 3 almost always ◯ + 4 ☐

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
never ◯ rarely ◯ + 1 sometimes ◯ + 2 frequently ◯ + 3 almost always ◯ + 4 ☐

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
never ◯ rarely ◯ + 1 sometimes ◯ + 2 frequently ◯ + 3 almost always ◯ + 4

Signature	Area Code	Phone Number	Total all 6 boxes from above: 4-5 = low risk, 6 -10 = high risk, 11 and above = very high risk	**Point Total** ☐

24600 Millstream Dr., Ste. 480 | Aldie, VA 20105 | Phone 703.327.7222 | Fax 703.995.4454