Courthouse Art of Dentistry

2250 Clarendon Blvd.
Store F
Arlington VA 22201
(703)778-0854

courthousedentistry@gmail.com
www.courthousedentistry.com

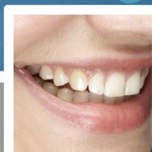


Chart #. ____________
FOR OFFICE USE ONLY

Patient Name: ______ Last ______ First ______ MI ______ Preferred Name

Title: ______ Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______ SS #. ______ Prev. Visit: ______

Email Address: ______ Best time to call: ______

Phone: ______ Home ______ Work ______ Ext ______ Mobile ______ Fax ______ Other

Address: ______ ______
______ City ______ State ______ Zip Code

Name of person, office, or other source referring you to our practice:

______

☐ Allergies	☐ Allergy - Anesthetic	☐ Allergy - Aspirin	☐ Allergy - Codeine
☐ Allergy - Erythro	☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin
☐ Allergy - Sulfa	☐ Anemia	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Bisphosphonate Usage	☐ Blood Disease	☐ Blood Pressure Disor
☐ Cancer	☐ Diabetes	☐ Dizziness	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma	☐ Head Injuries
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ HIV/AIDS
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Nervous Disorders	☐ Other(see chart doc)	☐ Other	☐ Pacemaker
☐ Pregnancy	☐ Pre-Med Heart	☐ Pre-Med Joint	☐ Radiation Treatment
☐ Respiratory Problems			

- [ ] Rheumatic Fever
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Please list other medical conditions and allergies:

Please list all medications you are currently taking:

When was your last dental exam?

How often do you brush?

How often do you floss?

Do you grind your teeth?

( ) Yes ( ) No

Have you ever had orthodontics?

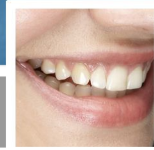
( ) Yes ( ) No

Have you ever smoked? # of years__________ # of packs/day__________

( ) Yes ( ) No

Do you smoke now? # of packs/day__________

( ) Yes ( ) No



The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: ______ Last ______ First ______ MI ______ Preferred Name

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Name of Insured: ______ Last ______ First ______ MI

Insured's Birth Date: ______ ID #. ______ Group #. ______

Insured's Address: ______

______ City ______ State ______ Zip Code

Insured's Employer Name: ______

Employer Address: ______

______ City ______ State ______ Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ______

Insurance Address: ______

______ City ______ State ______ Zip Code

IF APPLICABLE, SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured: ______ ______ ______
Last First MI

Insured's Birth Date: ______ ID #. ______ Group #. ______

Insured's Address: ______ ______
______ ______ ______
City State Zip Code

Insured's Employer Name: ______

Employer Address: ______ ______
______ ______ ______
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______

Insurance Address: ______ ______
______ ______ ______
City State Zip Code

A) Treament Fees: The investment necessary to complete my dental treatment is an estimate based on information obtained during the dental examination. Should my dental needs change, my estimate may be revised. The treatment fees given on my estimate are valid 30 days from the date of examination.

B) Financial arrangements: Financial arrangements must be secured prior to any treamtent being performed. Unless otherwise previously arranged, treatment fees are due in full at the time of service. I understand that I am responsible for the entire balance of the dental treatment rendered on my behalf. I understand that in the event that my balance becomes delinquent, Courthouse Art of Dentistry will forward my account information to a collection agency.

C) Insurance: Any insurance estimates given by this office are estimates only. I understand that I am responsible for full payment of sevices rendered on my behalf. Should this office agree to accept the assignment of benefits from my insurance, any balance that remains after my insurance has paid is my responsiblity. It is my responsibility to understand the specifications of my dental plan and to inform the dental office of any changes to my insurance.

D) Warranty Terms for Prosthetic Restorations: I understand that if my prosthetic restorations should fail for any reason excluding those related to or invoving accident/injury or patient non-compliance, they will be replaced by Courthouse Art of Dentistry at no cost within the first full year following the final insertion date. During the second year following my final insertion date, I will be responsible for 20% of the current replacement cost, 40% during the third year, 60% during the fourth year, 80% during the fifth year, and the full fee after 5 complete years. This warranty is based on regular observance of my recommended treatment plan and maintenance check ups. If appointments are missed and/or my treatment and maintenance plans are not followed as recommended, I understand that any warranty may be revoked at the doctor's sole discretion.

E) Cancellation Policy: I understand that Courthouse Art of Dentistry reserves the right to charge a cancellation fee of up to $100 per hour of scheduled time should I fail to give 2 full business days notice to reschedule or cancel my appointment.

F) Our staff at Courthouse Art of Dentistry is committed to providing the highest quality of dental care and services for our patients. Dental procedures require preparation and planning. This includes appropriate staffing, treatment room availability, and material preparation at specific times during our work day. We reserve specific time blocks in an attempt to meet patient schedules and the urgency of the dental need. If you have made an appointment with us, this time has been reserved exclusively for you, and we have prepared in advance for your visit.

By signing this document, I agree to accept the terms and policies stipulated in this document. Should I require futher clarification of any item on this form, I have the right and responsibility to request an explantion prior to signing. My signature on this form verifies that I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian____

Date:___________________________________

Response Date: [ ]

COURTHOUSE ART OF DENTISTRY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY:

This notice is in effect and remains in effect until we replace it.

1. OUR PLEDGE REGARDING DENTAL INFORMATION

The privacy of your dental information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our dental office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share dental information about you. We also describe your rights and certain duties we have regarding the use and disclosure of dental information. Throughout this notice we refer to your medical information as dental information.

2. OUR LEGAL DUTY

Law Requires Us to:
1. Keep your dental information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your dental information.
3. Follow the terms of the current notice.

We Have the Right to:
1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all dental information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:
1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR DENTAL INFORMATION

The following section describes different ways that we use and disclose dental information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose dental information. We will not use or disclose your dental information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use dental information about you to provide you with dental treatment or services. We may disclose dental information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share dental information about you to your other health care providers to assist them in treating you.
FOR PAYMENT: We may use and disclose your dental information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your dental information.
FOR HEALTH CARE OPERATIONS: We may use and disclose your dental information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.
ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your dental information for treatment, payment, and health care operations, we may use and disclose dental information for the following purposes.
Notification: We may use and disclose dental information to notify or help notify: a family member, your personal representative or another person responsible for your care. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, dental supplies, x-ray or other dental information for you.
Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of dental information.
Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the dental information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.
Specialized Government Functions: Subject to certain requirements, we may disclose or use dental information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
Court Orders and Judicial and Administrative Proceedings: We may disclose dental information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your dental information with law enforcement officials. We may share limited information with a law enforcement official concerning the dental information of a suspect, fugitive, material witness, crime victim or missing person. We may share the dental information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
Public Health Activities: As required by law, we may disclose your dental information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your dental information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose dental information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your dental information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share dental information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
Workers Compensation: We may disclose dental information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.
Health Oversight Activities: We may disclose dental information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose dental information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.
Appointment Reminders: We may use and disclose dental information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.
Alternative and Additional Dental Services: We may use and disclose dental information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:
1. Look at or get copies of certain parts of your dental information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the con- tact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your dental information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your dental information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your dental information by different means or to different locations. Your request that we communicate your dental information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your dental information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

COURTHOUSE ART OF DENTISTRY
2250 CLARENDON BLVD., STORE F, ARLINGTON, VA 22201
Phone: 703-778-0854

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.

I ACKNOWLEDGE AND HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW THIS NOTICE OF PRIVACY PRACTICES.

Name_________________________ Signature__________________________ Date__________________

I consent to the disclosure of my IIHI (Individually Identifiable Health Information) for purposes of treatment, payment, release of X – Ray or other health care operations
to those individuals that I have listed below:

• Name ___________________________________ Relationship _____________________
• Name ___________________________________ Relationship _____________________
• Name ___________________________________ Relationship _____________________
• Patient's Name (if under 18) ____________________ Relationship ______________________

Acknowledgement of Receipt of Privacy and Practices
** You may refuse to sign this acknowledgement**

I, __________________________, have received a copy of this office's privacy notice and Practices.

Patient or Guardian Signature _________________________________ Date ______________