WELCOME TO OUR PRACTICE

PATIENT INFORMATION...

Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age ____ Social Security Number _____

Street _____ Apt. ____ City _____ State ____ Zip ____

Home Tel.(____) _____ Cell.(____) _____ E-mail _____

Did you find our practice online? ❑ Yes ❑ No Referred By _____ (FIRST NAME) _____ (LAST NAME)

Have you ever been a patient of our practice? ❑ Yes ❑ No Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Medical Doctor _____ (FIRST NAME) _____ (LAST NAME)

Preferred Pharmacy _____ Tel. (____) _____

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(____) _____

Employer _____ Bus. Tel.(____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age ____ Tel.(____) _____

Street _____ Apt. ____ City _____ State ____ Zip ____

Driver's Lic.# _____ Employer _____ Bus. Tel.(____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. ____ City _____ State ____ Zip ____

Tel. (____) _____ Employer _____ Bus. Tel.(____) _____

INSURANCE INFORMATION...

Student: ..... ❑ Full Time ❑ Part Time ❑ Not ..... School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: .. ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: ..... ❑ Full Time ❑ Part Time ❑ Retired ❑ Not ..... Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY INSURANCE COMPANY...

Insurance Type: ❑ Dental ❑ Medical

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel.(____) _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel.(____) _____

SECONDARY INSURANCE COMPANY...

Insurance Type: ❑ Dental ❑ Medical

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel.(____) _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel.(____) _____

DENTAL INFORMATION...

Reason for today's visit _____ Are you in pain? ❑ Yes ❑ No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

- ❑ Discomfort, clicking, or popping in jaw
- ❑ Red, swollen, or bleeding gums
- ❑ A removable dental appliance
- ❑ Blisters / sores in or around the mouth
- ❑ Prolonged bleeding from an injury / extraction
- ❑ Recent infections or sore throat
- ❑ My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting
- ❑ Lost / broken filling(s)
- ❑ Teeth grinding / clenching
- ❑ Ringing in ears
- ❑ Broken / chipped tooth
- ❑ Gum disease
- ❑ Stained teeth
- ❑ Locking jaw
- ❑ Bad breath
- ❑ Burning tongue / lips
- ❑ Toothache
- ❑ Other _____
- ❑ Difficulty closing jaw
- ❑ Difficulty opening jaw
- ❑ Loose / shifting teeth
- ❑ Food caught between teeth
- ❑ Swelling / lumps in mouth

Last dental exam _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ❑ Yes ❑ No

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

MEDICAL HISTORY...

Are you in good health? ❑ Yes ❑ No • Heig_____ Weight_____ • Are you u_____the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you ever had general anesthesia? ❑ Yes ❑ No • Have you, or a family member, had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Mental health problems	❑	❑	Abnormal bleeding	❑	❑	Kidney trouble
❑	❑	High blood pressure	❑	❑	Problems with immune system *(possibly from med. / surg.)*	❑	❑	Bleeding tendency	❑	❑	Sexually transmitted diseases
❑	❑	Low blood pressure	❑	❑	Delay in healing	❑	❑	Blood transfusion	❑	❑	Contagious diseases
❑	❑	Mitral valve prolapse	❑	❑	Hay fever / Sinus problems	❑	❑	Blood disorder	❑	❑	Infectious mononucleosis
❑	❑	Heart murmur	❑	❑	Snoring	❑	❑	Bruise easily	❑	❑	Swollen ankles
❑	❑	Chest pain / Angina	❑	❑	Sleep apnea / CPAP	❑	❑	Eye disease / Glaucoma	❑	❑	Arthritis / Joint disease
❑	❑	Heart attack(s)	❑	❑	Respiratory problems	❑	❑	Jaundice / Liver disease	❑	❑	Prosthetic implant
❑	❑	Irregular heart beat	❑	❑	Tuberculosis	❑	❑	Hepatitis	❑	❑	Joint replacement
❑	❑	Cardiac pacemaker	❑	❑	Emphysema	❑	❑	Gallbladder trouble	❑	❑	Osteoporosis / Osteopenia
❑	❑	Heart surgery	❑	❑	Do you smoke or vape? *If so, how much a day*_____	❑	❑	Fainting spells	❑	❑	Osteonecrosis
❑	❑	Damaged heart valves				❑	❑	Convulsions / Epilepsy	❑	❑	Stomach ulcers / Acid reflux
❑	❑	Pneumonia / Bronchitis / Chronic cough				❑	❑	Stroke	❑	❑	GI troubles / IBS / Colitis
❑	❑	Chronic fatigue / Night sweat	❑	❑	Do you use chewing tobacco	❑	❑	Thyroid trouble	❑	❑	Tumor or growth
❑	❑	Trouble climbing 1-2 flights of stairs	❑	❑	A history of marijuana or other drug use	❑	❑	Diabetes	❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Anemia				❑	❑	Low blood sugar	❑	❑	Are you on a diet
❑	❑	Asthma	❑	❑	A history of alcohol abuse	❑	❑	Are you on dialysis	❑	❑	Contact lenses

MEDICATION & ALLERGIES...

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
									❑	❑	Blood thinners (Coumadin, Aspirin, Eliquis, Xarelto)
									❑	❑	Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years?

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
❑	❑	Sodium pentothal / Valium / other tranq.	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	Do you have any known allergies

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

❑ I permit the office to communicate with me via text message on my cell phone.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

Oral Screening Consent Form

Complete each time the examination is performed and place in the patient's file

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health 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 of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patient profile is as follows:

Increased risk: *patients ages 18-39*
-sexually active patients (HPV 16/18)
High risk: *patients age 40 and older; tobacco users (any age, any type within 10 years)*
Highest risk: *patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer*

We have recently incorporated ViziLite® Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral 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. The ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is 95.00.

Yes, I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

No, I would prefer not to have the ViziLite Plus exam at this time.

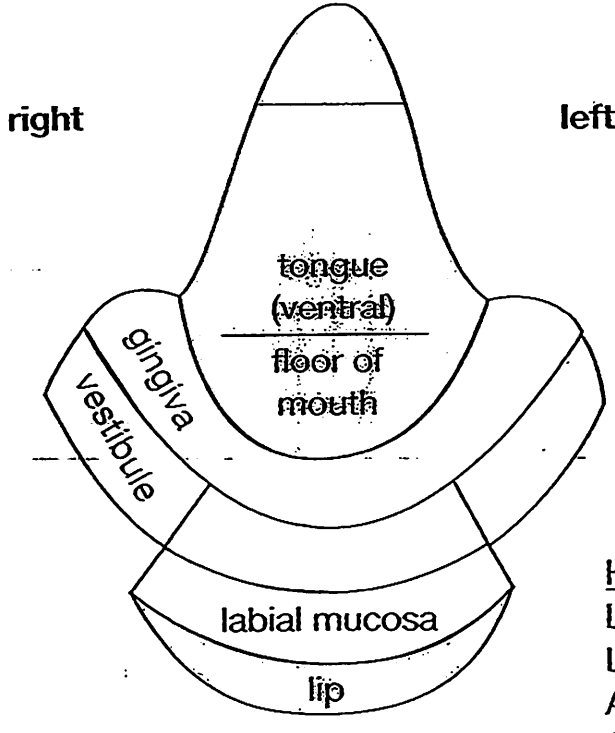
Print name: _____

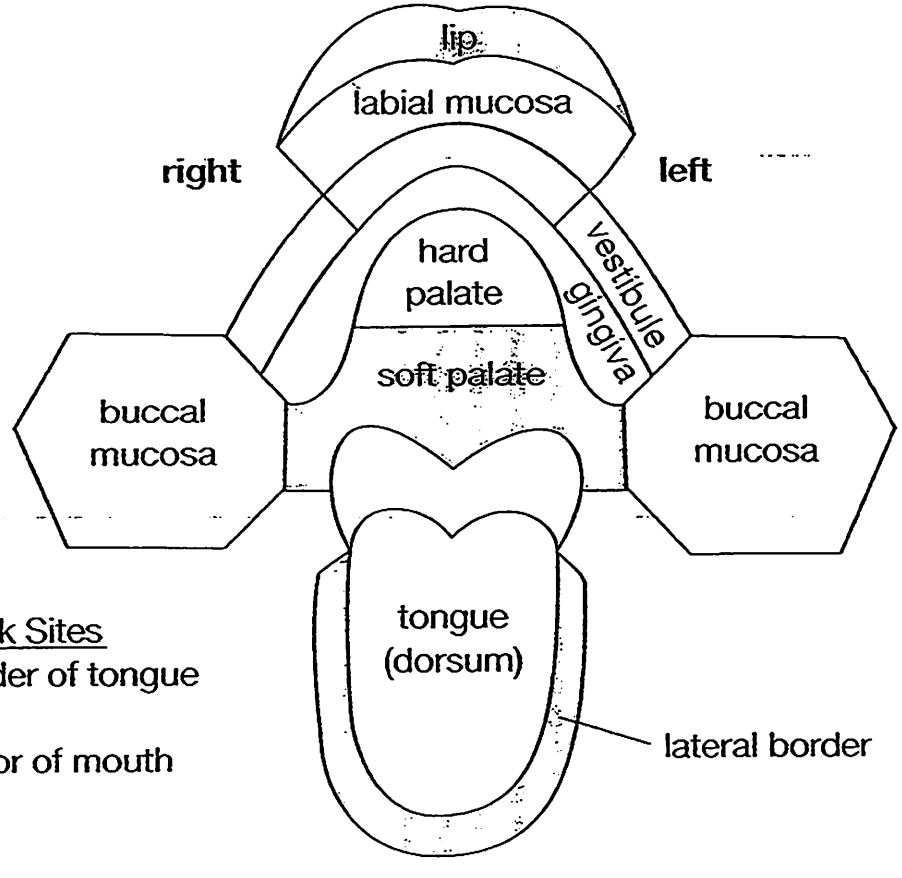
Signature: _____ Date: _____

VizLite Plus
Oral Lesion Identification and Marking System
Better screening saves lives™
VizTBlue SSC

Patient _____ ID _____

Clinician _____ Date _____





Highest Risk Sites
Lateral border of tongue
Lip
Anterior floor of mouth
Soft palate

KENNETH M. VAN STRALEN, D.D.S.

3111 Telegraph Corner Lane Suite 201

Alexandria, VA 22310

APPOINTMENTS

A minimum charge may be made to failed or cancelled appointments without prior notification of 48 hours. This fee covers only a portion of the overhead, such as salaries, electricity, heat, etc./ which must be paid whether you are here or not. Once an appointment has been made, please remember that this time has been reserved for you.

PAYMENTS

Payment for dental services rendered is due at the time of treatment or as mutually agreed. If it becomes necessary to refer this account to an attorney for collection, I hereby agree to pay attorney fees in the amount of the third of the amount of the debt. I also agree to pay 1.5% per month (18% per annum) in interest on my unpaid balance after 60 days.

INSURANCE

To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payments of fees. We will prepare the necessary forms or reports to help you obtain benefits from your insurance company(ies).

PATIENT SIGNATURE_____DATE_____

Parent or Guardian if Patient is a Minor

SMILE ASSESSMENT FORM

Please consider each statement carefully and circle YES or NO. The doctor and members of the dental team will discuss your responses with you in confidence.

1. I am concerned about the appearance of my teeth or my smile.	YES	NO
2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth.	YES	NO
3. I am concerned about the position or angle of one or more of my teeth.	YES	NO
4. I am concerned about the shape of one or more of my teeth.	YES	NO
5. In social situations, I am sometimes embarrassed by my teeth or my smile.	YES	NO
6. There are some things about my upper front teeth that I would like to change.	YES	NO
7. There are some things about my lower front teeth that I would like to change.	YES	NO
8. I have old fillings or previous dental treatment that is no longer satisfactory to me.	YES	NO
9. I am missing one or more of my teeth.	YES	NO
10. I am interested in learning more about esthetic dentistry.	YES	NO

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank you.

Kenneth Van Stralen D.D.S. 3111 Telegraph Corner Lane Suite 201 Alexandria, VA 22310 (703) 317-3900 Fax (703) 317-3352

KENNETH VAN STRALEN, DDS, PLC

[Insert Name of Practice]

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Form No. T303HA

KENNETH VAN STRALEN, DDS, PLC

[Insert Name of Practice]

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, post-cards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.
If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may 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 upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Provider Contact Office: _____

Telephone: _____ Fax: _____

E-Mail: _____

Address: _____