WELCOME TO MAVROMATIS DENTAL

2248 Sunstates Ct. Suite #103
Virginia Beach, VA 23451
757-496-9123

Patient Information (confidential) Today's Date _____ /_____ /__________

Last __________________________ First_____________________ Middle Initial _____

I prefer to be called: ________________ Male______ Female______

Address ____

City _________________________ State _____ Zip _______

Single ______ Married _____ Divorced_____ Widowed____

Date of Birth ______ /______ /_________ Age ____

SS# ____________________________

Your Occupation _____________________________

Best Email _______________________________________ SS# ________ - _______ - ____________

Cell Phone ____________ /___________ /______________ Do you receive text messages? Y / N

Home Phone ____________ /___________ /______________

Work Phone ____________ /___________ /______________

Best way to communicate with you? Cell ____ Home ____ Email ____ Work ____ Text ____

Whom may we thank for referring you? __________________________

Other family members who see us: ____________________________

If you are under 18 years of age, Parent/Guardian's Name ____________________________________

Parent/Guardian's Employer ____

Parent/Guardian's Occupation ____

Parent/Guardian's Work Phone ___________ /___________ /______________

MAVDENTAL.COM

Spouse Information

Name ______________________________

Contact # _____________________

SS# ______________________

Date of Birth ________________

Primary Insurance

Dental Coverage? __ Yes __ No
Insurance Co. Name _____________
Insurance Co. Address _____________
Insurance Co. Phone # _________________
Group # (Plan, Local or Policy #) _________________
Insured's Name ___________ Relation _____________
Insured's Birthdate __________
Insured's ID # _____________
Insured's Employer _________________________________
Employer's Address ____

Secondary Insurance

Dental Coverage? __ Yes __ No
Insurance Co. Name _____________
Insurance Co. Address _____________
Insurance Co. Phone # _________________
Group # (Plan, Local or Policy #) _________________
Insured's Name ___________ Relation _____________
Insured's Birthdate __________
Insured's ID # _____________
Insured's Employer _________________________________
Employer's Address ____

Emergency Contact

Name _______________________________ Relation __________________
Phone # _____________________
Address ____

Patient Medical History

Your current physical health is: Good Fair Poor
List your allergies (medicine, metals, latex etc...) ________________________________
List your medications ____
Are you taking medicine for osteoporosis? Yes No
Physician ___________________ Are you pregnant? Yes No If yes, how many weeks? _____
Are you under medical treatment now? Yes No Describe ________________
Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No
If yes, please explain ____
Do you use tobacco? Yes No Do you use controlled substances? Yes No Details: ________

Do you have or have you had any of the following:

High Blood Pressure	Yes No	ADD/ADHD	Yes No
Heart Attack	Yes No	Anemia	Yes No
Rheumatic Fever	Yes No	Emphysema	Yes No
Prolonged Bleeding	Yes No	Cancer/Chemotherapy	Yes No
Fainting/Seizures	Yes No	Arthritis	Yes No
Asthma	Yes No	Joint Replacement or Implant	Yes No
High Blood Pressure	Yes No	Hepatitis/Jaundice	Yes No
Epilepsy/Convulsions	Yes No	Stomach Ulcers	Yes No
Leukemia Arthritis	Yes No	Chest Pains	Yes No
Diabetes	Yes No	Stroke	Yes No
Osteoporosis	Yes No	Sinus Problems	Yes No
Kidney Disease	Yes No	Tuberculosis	Yes No
AIDS or HIV Infection	Yes No	Radiation Therapy	Yes No
Thyroid Problem	Yes No	Glaucoma	Yes No
Heart Disease	Yes No	Liver Disease	Yes No
Cardiac Pacemaker	Yes No	Heart Trouble	Yes No
Heart Murmur	Yes No	Respiratory Problems	Yes No
Hemophilia	Yes No	Herpes/Fever Blisters	Yes No
Angina	Yes No	Mitral Valve Prolapse	Yes No

Are there any other medical conditions you have that we should know about? _______________________
____

Patient Dental History

Why are you here today? ____
Are you happy with your current smile? Yes No If no, please explain ____________________________
____
Do you take antibiotics before dental treatment for any reason (heart murmur, transplant etc...)? Yes No
Do you use an electric toothbrush? Yes No ________

Do your gums bleed while brushing or flossing? Yes No ________

Are your teeth sensitive to hot or cold? Yes No ________

Do you feel pain to any of your teeth? Yes No ________

Do you have any sores or lumps in or near your mouth? Yes No ________

Have you ever had neck or jaw injuries? Yes No ________

Have you ever experienced any of the following problems?

Clicking Yes No ________

Pain (joint, ear, side of face) Yes No ________

Difficulty in opening or closing Yes No ________

Difficulty in chewing Yes No ________

Do you have frequent headaches? Yes No ________

Do you clench or grind your teeth? Yes No Not sure

Do you bite your lips or cheeks frequently? Yes No ________

Have you ever had any difficult extractions in the past? Yes No ________

Have you had any orthodontic treatment? Yes No ________

Do you wear dentures or partials? Yes No ________

Have you ever been taught how to properly brush and floss? Yes No ________

Authorization and Release

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be help in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature of Patient (or Parent/Guardian) ____________________ Date ____________

Office Financial Policy

Our goal is to provide the best quality healthcare treatment available today. Following your diagnosis, we will advise you of a treatment plan that will help you to maintain optimum dental health. Additionally, payment options will be discussed.

Payment is due at the time services are rendered. We have several payment options for your convenience:

Cash
Check
Mastercard, Visa, Discover,
CareCredit Monthly Payment Plan**

**CareCredit applications are available at the front desk. CareCredit is a low monthly payment plan with no annual fees. CareCredit offers interest free payments up to 10 months for qualifying accounts.

Insurance

We will be happy to process your insurance claim, and ESTIMATE your deductible and portion not covered by the insurance company (co-payment). The estimated amount not covered by your insurance is due at the time of treatment and may be paid by one of the following options listed above. Out estimates are subject to final approval by your insurance company, therefore the amount due could change. If the insurance company has not paid within 30 days, you are responsible for any remaining balance.

Initial Payments:

Our office requires a deposit of one half at the start of major treatment (crowns, bridges, dentures etc…) and payment in full once treatment is completed.

I understand that I am responsible for any interest, collection fees, legal fees, deductibles, and co-payments on my account and/or my family's account. If my insurance has not paid after the 30 days, I am responsible for any remaining balances and financial charges that may occur.

24 Hour Notice:

We require a 24 hour notice for cancellations. Out office charges a fee for broken appointments without proper notification.

Name: ____

Signature: ____

Relationship to patient if patient is a minor: ______________

HIPPA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

The patient understands that:

- Protected health information maybe disclosure use for treatment payment or healthcare operations –
- The practice has a notice of privacy practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

Below is a list of ways the office may contact you. Please provide contact information so we may contact you regarding appointment times, scheduled treatments, documents, and payments.

Cell # ____________________________

Home # __________________________

Email ____________________________

Emergency # ______________________

List names, if any, who can have access to your dental/medical chart information: _______________

____

____ Patient gives this office permission to forward any verified contact information and protected health information to patient specialists. Office may discuss pertinent patient chart information including protected health information, with labs, and product representatives involved in patient's case through verified unsecured and unencrypted means. The privacy rule allows those doctors, nurses, hospitals, laboratory technicians and other healthcare providers that are covered entities to use or disclose protected health information such as x-rays, laboratory and pathology reports, diagnosis, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers including providers were not covered entities, to treat a different patient, or to refer the patient. See 45CFR164.506. Any source other than your Healthcare Providers will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS is the only means of communication with those involved in a patient's case, which is considered HIPPA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of protected health information to be hand-delivered.

Print Patient's Name: ____ Date: _______

Print Legal Guardian's Name: ____________________________________ Date: _______

Signature of Patient or Legal Guardian: _____________________________

_____ Patient refused to sign HIPPA Consent.