DistrictDentalGroup OF DC

PAUL KOURTSOUNIS D.D.S

Tel: 202-296-9448

1234 19TH ST. NW STE. 200
WASHINGTON, DC 20036

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

HOME:
CELL:
OTHER:
PAGER:
FAX:

E-Mail:

Referral? ☐Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP

Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

WORK: X
DIRECT:
OTHER:
PAGER:
FAX:

E-Mail:

INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

SECONDARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

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☐Y☐N Are you currently having dental discomfort? If yes, explain:
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain:
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain:
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Have missing teeth been replaced?
☐Y☐N Orthodontic appliances now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you want to become a regular continuing care patient in our practice?
☐Y☐N Do you want your mouth properly restored and pain free?
☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

The most important concerns regarding my dental treatment are:

What factors are most important for your satisfaction with our office?

Any additional concerns/comments?

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

☐Y☐N Any unusual speech habits? If yes, explain:
☐Y☐N Any lost teeth? If yes, list:
☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

PRIMARY PHYSICIAN INFORMATION

Physician: Telephone:
Clinic/Facility:

MEDICAL HISTORY

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GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years?
☐Y☐N Any serious illnesses/surgeries?
☐Y☐N Use tobacco in any form? If Yes, Type:
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BULIMIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐CHICKEN POX
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐FREQUENT EAR INFECTIONS
☐FREQUENT HEADACHES
☐HEARING PROBLEMS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐PACEMAKER
☐OTHER – PLEASE LIST:
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐CODEINE
☐DAIRY
☐LATEX
☐LACTOSE INTOLERANCE
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐SLEEPING PILLS
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS
☐NONE
☐OTHER – PLEASE LIST:

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐OTHER (PLEASE LIST BELOW)
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

Financial Policy

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We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in-network provider for your plan. If we are not an in-network provider, review your plan details, as in many cases insurance reimbursement is very similar.

Payment is due in full at time of service.

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

- **Workers Compensation claims** will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. Any amount not covered by the carrier, will be your responsibility.

- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.

- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover)
  - 10% Discount for our uninsured cash/check paying patients
  - Various financing options with CareCredit®

- **Balances left over 90 days will incur an 18% or $10 minimum monthly finance charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Signature: Date:

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2018

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions if, for example it interferes with payment, daily operations, or providing quality dental care. District Dental Group of DC, PLLC has your consent to contact you by telephone, email, or text messages for all correspondence.

Signature: **Date:**

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

☐ I give permission for the following communications to be used by District Dental Group of DC and its affiliates. **(please check all that apply)** :

☐ Cell phone: ☐Text Message reminders permitted
☐ Home phone ☐ Work ☐ E-Mail:

☐ I am granting permission for District Dental Group of DC PLLC and its affiliates to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for District Dental Group of DC PLLC and its affiliates to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back
☐ Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign

☐ Communication barriers

☐ Emergency situation

☐ Other – please list:

_____

_____

_____

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PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to District Dental Group of DC, PLLC and its affiliates of the dental/medical benefits otherwise payable to me.

I hereby authorize District Dental Group of DC, PLLC to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental/medical claims and/or discussing treatment options with other dental/medical professionals. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature:_____ Date:_____