STEPHENS CITY FAMILY DENTISTRY
Young H. Lim D.D.S. P.C. Richard L. Taliaferro D.D.S Dong S. Park D.D.S.

175 Warrior Drive
Stephens City, Virginia 22655

Telephone (540) 869-2600
Fax: (540) 869-7948

PATIENT INFORMATION

PATIENT'S NAME: _____ Date of Birth: _____ / _____ / _____

EMAIL ADDRESS: _____

Child Name: _____ D.O.B: _____ ***Child Name***: _____ D.O.B: _____

Child Name: _____ D.O.B: _____ ***Child Name***: _____ D.O.B: _____

SOCIAL SECURITY #: _____ - _____ - _____

MAILING ADDRESS:
Home Address: _____ City:_____ State_____ Zip _____

If other than home location: _____ City _____ State _____ Zip _____

CONTACT INFORMATION:
Home phone #:_____ Cell phone #:_____ Work phone #:_____

EMERGENCY CONTACT Name: _____ Phone#: _____

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How did you hear about our Practice?

We would love to know who to thank for welcoming you as a patient!

_____

DENTAL INSURANCE: ***If you have dental insurance, please provide the following information, and present your Dental Insurance CARD to RECEPTIONIST in order that we may file for today's claim.***

** **PRIMARY** Dental Insurance Company: _____

Ins. Company Address: _____ Phone # _____

City:_____ State:_____ Zip_____ FAX: _____

Policy Subscriber: (policy is under this person's name): ID #: _____

Name: _____ D.O.B._____ SS #: _____

Employer providing insurance: _____ Group #:_____

Employer's Address: _____ Phone #: _____
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Time 2:15 PM

Stephens City Family Dentistry

Eaglesoft Medical History

Date 7/19/2018

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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:_____

STEPHENS CITY FAMILY DENTISTRY

Young Lim, D.D.S. P.C. Richard L. Taliaferro, D.D.S. P.C. Dong S. Park D.D.S.

175 Warrior Dr. Stephens City, Virginia 22655 Telephone (540) 869-2600

DENTAL INSURANCE and YOUR ACCOUNT

As a courtesy to our patients, we file claims electronically, however, because insurance plans are different, we have listed some guidelines that may apply:

1. We are not listed as a Preferred Provider with any insurance company except **Delta Dental Premier** and some **Cigna** plans; however as a courtesy, we do file your claims with your insurance company.
   a. If your insurance company pays our office directly, you will be responsible for payment of *your portion* at the time of service.
   b. If your insurance company pays the subscriber directly, you will be responsible for the *full payment* at the time of service.
   c. You may want to check with your insurance company to see if they have a list of "in-plan" providers that will afford you maximum benefits for your plan.

2. You are responsible for tracking your claim through an EOB (Explanation of Benefits) which is sent to you by your insurance company.
   a. Within **30 days** if you have not received an EOB from your insurance company, you need to contact them to determine the status of your claim.
   b. If your insurance company hasn't received a claim from us, you need to call them to verify pertinent information:
      - *mailing address* for submitting claims
      - *name & phone number* of person with whom you spoke.
   c. Inform our office with correct information if a new claim needs to be filed.

If your balance is *not* cleared in 60 days:
- Any scheduled appointments for you and your family will be canceled.
- You will be terminated as a patient with our office.
- Your account will be turned over to a collection agency.

If you have any questions regarding this policy, please contact our office at (540)869-2600.

Patient's Signature _____ Date _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By Signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of our protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Young H. Lim, D.D.S. P.C. ,Richard L. Taliaferro, D.D.S., Dong S. Park D.D.S.
(540) 869-2600
175 Warrior Drive Stephens City, VA 22655-0819

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Name of Patient or Guardian and Dependents:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

PERMISSION TO CONTACT

I hereby give my permission to the following individuals to contact, or be contacted by, Stephens City Family Dentistry regarding details of my account or patient information status (i.e. parents who are Subscribers of Dental Insurance on which I am covered).

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

_____ _____
Patient Signature Date

FINANCIAL AGREEMENT

Patient portion will be collected at the time of service. A finance charge will apply and computed by a "Periodic Rate" of 1 ½% per month (or a minimum of 50 cents on balances under $5.00) which is an ANNUAL PERCENTAGE RATE of 18% that will apply to the previous balance without deducting current payments and/or credits appearing on any given charge sale. Upon default in the payment of any installments, including charges for broken appointments or returned checks for non-sufficient funds, the above rate will be charged on the unpaid balance at 1-1/2% per month until the delinquency is paid.

Patient(s) further agree to pay any and all collection fees incurred and legal expenses, including but not limited to collection agency and attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debt on accounts with this provider. I understand that I am ultimately responsible for the payment of this bill, regardless of insurance allowance and payments.

Stephens City Family Dentistry is considered an out of Network, non-participating provider for all insurance companies, excluding Delta Dental Premier and some Cigna policies. Stephens City Family Dentistry will file all insurance claims for you as a courtesy.

****I know that after 30 days, whether or not insurance has paid, I am responsible for the total balance due on my account. I understand that Stephens City Family Dentistry reserves the right to dismiss me as a patient for reasons of non-payment.**

PATIENT'S AUTHORIZATION

I hereby authorize Young H. Lim D.D.S. P.C., Richard L. Taliaferro D.D.S. or Dong S. Park D.D.S. (Stephens City Family Dentistry) to apply for benefits on my behalf for his covered services rendered and request that payments from my insurance company be made directly to Young H. Lim D.D.S. P.C., Richard L. Taliaferro D.D.S., or Dong S. Park D.D.S. (Stephens City Family Dentistry). I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to Stephens City Family Dentistry. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either myself or Stephens City Family Dentistry at any time in writing.

Dependents:_____

Signature:_____

The patient is entitled to a copy of this information and agreement form, if desired.

There is a $67.00 for missed appointments without 24 hour notice.