Consent for Treatment, Communications & Office Policies

We make every effort to provide service and quality dental care for you so that you can treat and maintain your health as quickly, efficiently and as affordable as possible. I have a personal and ethical responsibility to care for your health to the best of my ability.

I, _____ consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my Dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results. I understand that the Dentist reserves the option to alter treatment. These changes may increase the fees, I do not require to be notified if fees are lower than anticipated.
4. I will pay in full for any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for any costs that my insurance does not cover.
5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Patients with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service. Guarantee any amount not covered by insurance with your Credit Card on file up to an agreed maximum amount, which will enable you to use your Credit Card to automatically cover amounts not paid by your insurance. We have expanded our payment policies to provide our patients with more flexible financial options. Please speak to the office manager if you have any questions.

Our Office is fully approved and accredited user of the Visa and MasterCard Health Care Program and your information is stored encrypted and secure.

If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

- Insurance pre-authorization $30 consultation fee
- There is a $30.00 processing charge for non-sufficient funds or returned checks.
- Records can be viewed at any time.

Please make every effort to be on time for your appointments. If you are more than 15 minutes late we may need to reschedule, but we will try to accommodate you if the schedule allows. Failure to make an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you can't make an appointment (except in the case of an emergency) we request that you notify us within 24 hours of your appointment to reschedule. A $50-$100 fee will be charged for missed appointments, this fee must be paid before you can schedule your next appointment. This money will be matched by Dr. Arbuckle and will be donated to the Arlington Free Clinic for their new dental care department.

Electronic Communication: The dental practice may communicate with me electronically at the email address and/or mobile phone number listed on file. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

I can withdraw my consent to electronic communications at anytime by opting out or calling: (703)243-9365

I have read and agree to comply with the office policies of Eric L. Arbuckle DDS, PLC
I authorize the release of information related to dental claims filling

_____	_____	_____
Signature of Responsible Party	Date	Relationship to Patient

Welcome to Our Practice

Patient Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Home Phone: _____ Work: _____ Cell: _____
Social Security # (required) _____ Date of Birth: _____
Employer & Occupation: _____
Emergency Contact: _____ Phone:_____
Who referred you to our office? _____

Date of last dental visit:_____ Reason for today's visit:_____
Date of last X-rays/ Panoramic: _____ Name of Physician: _____
Have you had any major surgery in the last 2 years? Yes: □ No: □
Due to a medical condition, do you **PREMEDICATE**: Yes: □ No: □
Please list any prescribed medications you are taking:

_____
_____
Allergies/Sensitivities (please list):_____
Penicillin Clindamycin Latex Epinephrine Codeine Other
Please circle any and all of the following medical conditions that you have had/having:
Are you pregnant? No / Yes _____how many weeks? Are you breastfeeding? No / yes

AIDS / HIV	Epilepsy	Jaundice/Liver Problem	Sinus Problems
Allergies	Glaucoma	Leukemia	Stroke
Angina	Head Injuries	Mental Disorder	Swollen Ankles
Artificial Joints	Hearing Aids/Deaf	Nervous Disorder	TMJ/TMD
Asthma	Heart Attack/Failure/Disease	Pacemaker	Vision Problem/Blind
Blood Disease	Heart Murmur/MVP	Periodontal Disease	Thyroid
Breathing	Heart Surgery/Condition	Radiation Treatment	Tuberculosis/TB
Problems	Hepatitis: A, B, C	Respiratory Problems	Transplants
Cancer	High Blood Pressure	Rheumatic Fever	Tobacco use
Chronic Cough	Seizures	Sickle Cell	Explain _____
Diabetes			Other:_____

Are your happy with your smile? Yes □ No □
Are you happy with the color of your teeth? Yes □ No □
Are you interested in straightening your teeth? Yes □ No □
Do any of your teeth hurt? Yes □ No □
Do your gums bleed? Yes □ No □
Do you use an electric tooth brush? Yes □ No □
Do you experience a bad taste in your mouth? Yes □ No □
Is your bite giving you trouble? Yes □ No □
Do you grind or clench your teeth? Yes □ No □
Do you want to change any of your teeth or crowns? Yes □ No □
Do you know the relationship between periodontal disease and heart disease? Yes □ No □

Please read and sign: To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in health, or medications, I will inform the dentist at the next appointment.
Signature: _____ Date: _____

Financial Responsibility

Responsible Party Name : _____

Employer Name and Address: _____

Social Security Number(required): _____ Home phone: _____

Insurance Information

Insurance Company Name: _____Subscriber DOB _____

Subscriber Name: _____ Relationship to patient: _____

Subscriber Id/SS: _____Group Number: _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

• Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
• Obtaining payment from third party payers (e.g. my insurance company);
• The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature _____ Date _____

Eric L. Arbuckle DDS, PLC ***Phone (703)243-9365 Fax (703)525-9353***
Perfectsmilesva@gmail.com ***www.perfectsmilesva.com***