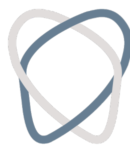

DC DENTAL SPA

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the best treatment. Please take your time and answer each question as completely and honestly as possible.

Patient Information

Today's Date: ___________________

☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr.

First Name _________________________ Middle Initial _____ Last Name ______________________________

Date of Birth _________________ Age ______ ☐ Male ☐ Female SSN# _______-______-_______

Address ____ City _______________ State _____ Zip _________

How long have you been a resident at current address? ______ (if less than 3 years, please provide previous address)

Previous Address ____________________________________ City _____________ State _____ Zip ________

Email Address ____ Telephone Number ___________________

Preferred Contact Method: ☐ Calls ☐ E-mail ☐ Text Messages

Occupation __________________________ Employer ______________________________

Address ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact ____________________________ Relationship to Patient __________________________

Telephone Number ____________________ Address ____

Primary Care Physician _______________________________ Telephone Number _______________________

Address ____

How did you hear about us?____

Who may we thank for referring you to us?____

Dental Insurance Information

Primary Dental Insurance Company

Insurance Company Name ____

Address ____ City ______________ State _____ Zip ____________

Telephone Number ____________________

Primary Insured of Primary Insurance

Name ____________________________ Date of Birth ________________ SSN# _______-______-_______

Group Policy # ________________________ Member ID ____________________________

Relationship to patient ____________________

Employer ________________________

Secondary Dental Insurance Company

Insurance Company Name ____

Address ____ City ______________ State _____ Zip ____________

Telephone Number ____________________

Primary Insured of Secondary Insurance

Name ____________________________ Date of Birth ________________ SSN# _______-______-_______

Group Policy # ________________________ Member ID ____________________________

Relationship to patient ____________________

Employer ________________________

____(Initials) I hereby authorize assignment of my insurance rights and authorize benefits to be paid directly to the provider for any services rendered. I fully understand I am solely responsible for any charges or balances not paid by my insurance company.

Account Responsibility

(Please fill out this portion if patient's financial responsibility is someone's other than self)

Name of Responsible Party __________________________________

Relationship to Patient ___________________________

SSN# _______-______-_______ Driver's License # ______________________ State ______

Address ____ City ______________ State _____ Zip ____________

Telephone Number ______________________

Dental History

Part I. Dental Experiences & Symptoms

1. What is the main reason for your visit? ____

2. Have you had dental X-rays in the past year? ☐ No ☐ Yes, please specify ______________________

3. Are you experiencing any of the following symptoms? (please check all that apply)

   ☐ Sensitive teeth ☐ Bleeding/sore gums ☐ Burning sensation ☐ Swelling inside mouth ☐ Sore jaw

   ☐ Difficulty chewing ☐ Recession ☐ Tartar buildup ☐ Toothache ☐ Filling fell out ☐ Yellowing teeth

   ☐ Difficulty swallowing ☐ Dry mouth ☐ Sinus problems ☐ Bad breath ☐ Abscess

4. Are you concerned about your breath or the appearance of your teeth or face? (If yes, please check all that apply)

   ☐ Yellowing/graying teeth ☐ Crowded/crooked teeth ☐ Spacing between teeth ☐ Facial profile

   ☐ Bad breath ☐ Appearance of gums

5. Have you experienced any injuries to your teeth, face and jaw? ☐ No ☐ Yes, please explain

   ____

Part II. At-Home Oral Hygiene Regimen

1. Check the following you regularly use at home (please check all that apply)

   ☐ Soft toothbrush ☐ Medium toothbrush ☐ Hard toothbrush ☐ Powered toothbrush ☐ Oral irrigator

   ☐ Dental floss ☐ Floss threader ☐ Denture cleaner/adhesive ☐ Fluoride toothpaste/rinse ☐ Whitening products

2. Estimate how long it takes you to clean your teeth and gums

   Brushing ______ (minutes) Flossing ______(minutes)

   Brush ______ times a day & ______ times a week

   Floss ______ times a day & _______ times a week

3. Do any conditions make it difficult for you to adequately clean your teeth? (If yes, please check all that apply)

   ☐ Hold a toothbrush ☐ Use dental floss ☐ Brush/floss for any length of time ☐ Poor vision

Medical History

Do any of the following chief complaints apply to you?

Y	N	Are you currently in any pain? If yes, please explain:
Y	N	Are you currently pregnant? If so, how far along are you?
Y	N	Do you feel your oral condition is affecting your general health in any way? If yes, please explain:
Y	N	Diet limited to semisolid, soft, or liquid foods
Y	N	Mouth sores
Y	N	Numbness in lower lip
Y	N	Difficulty chewing
Y	N	Numbness in jawbone
Y	N	Difficulty speaking
Y	N	Tingling in jawbone
Y	N	Nutritional disorders
Y	N	Facial pain
Y	N	Pain in jawbone
Y	N	Pain in jaw joint
Y	N	Jaw clicks
Y	N	Head pain
Y	N	Pain when swallowing
Y	N	Upper jaw locks
Y	N	Lower jaw locks
Y	N	Limited opening of jaw
Y	N	Teeth do not meet properly
Y	N	Loss of teeth
Y	N	Poorly fitting dental appliance (i/e: fixed and/or removable dentures/retainers/nightguard)

List of any medications/substances which have caused an allergic reaction:

Y	N	Antibiotics; if yes, please specify:
Y	N	Aspirin
Y	N	Barbiturates
Y	N	Codeine
Y	N	Lidocaine
Y	N	Latex
Y	N	Metals
Y	N	Others, please list:

List of medications/substances you are currently taking:

Y	N	Antibiotics; if yes, please specify:
Y	N	Aspirin
Y	N	Insulin
Y	N	Anticoagulants
Y	N	Muscle relaxants
Y	N	Barbiturates
Y	N	Blood thinners
Y	N	Pain medications
Y	N	Codeine
Y	N	Sleeping pills
Y	N	Cortisone
Y	N	Sulfa drugs
Y	N	Diet pills
Y	N	Heart medication
Y	N	Tranquilizers
Y	N	Medication for osteoporosis
Y	N	Bisphosphonates
Y	N	Herbal supplements
Y	N	Other, please specify:

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

Y	N	Abnormal bleeding	Y	N	Glaucoma
Y	N	Alcohol abuse	Y	N	Gout
Y	N	Allergies; if yes, please explain:	Y	N	HIV positive/AIDs
Y	N	Anemia	Y	N	Heart attack
Y	N	Arthritis	Y	N	Heart disease
Y	N	Asthma	Y	N	Hearing impairment
Y	N	Autoimmune disorders; if yes, please explain:	Y	N	Hepatitis A, B or C; please specify:
Y	N	Artificial bone	Y	N	Hemophilia
Y	N	Artificial heart	Y	N	Hypoglycemia
Y	N	Blood pressure: high or low?	Y	N	Hyperglycemia
Y	N	Back or spine	Y	N	Kidney disease
Y	N	Blood transfusion	Y	N	Leukemia/Lymphoma

Y	N	Cancer/Chemotherapy; if yes, please explain:	Y	N	Liver disease
Y	N	Chest pain	Y	N	Migraines
Y	N	Congenital heart	Y	N	Multiple sclerosis
Y	N	Chronic bronchitis	Y	N	Muscular dystrophy
Y	N	Chronic fatigue	Y	N	Muscle spasms/cramps
Y	N	Colitis	Y	N	Psychiatric disorders
Y	N	Diabetes	Y	N	Rheumatoid arthritis
Y	N	Dizziness	Y	N	Rheumatic fever
Y	N	Difficulty breathing	Y	N	Scarlet fever
Y	N	Drug abuse	Y	N	Seizures
Y	N	Depression	Y	N	Smoker/tobacco user
Y	N	Emphysema	Y	N	Shingles
Y	N	Epilepsy	Y	N	Stroke
Y	N	Fainty spells	Y	N	Tuberculosis
Y	N	Frequent headaches	Y	N	Thyroid disorders
Y	N	Others, please explain:	Y	N	Ulcers

Consent to Dental Treatment

I, ____________________________, consent to the dental treatment presented to me on _______________.

I understand that as the treatment proceeds, there may be a need to change the treatment plan. If this occurs, I expect to be informed before the change is instituted. I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment, I agree to report them to DC Dental Spa as soon as possible.

I understand that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following post-care protocols, following home care instructions, including good oral hygiene and dietary instructions. I further agree to report the office of any changes in my health as soon as possible.

I acknowledge that no guarantees or assurances have been given by a DC Dental Spa employee as to the results of procedures.

I authorize the dentist to complete the treatment and/or procedures as described.

_______________________________ Patient's Signature	______________________ Date
_______________________________ If a minor, parent/guardian's signature	______________________ Date
_______________________________ Witness's Signature	______________________ Date
_______________________________ Doctor's Signature	______________________ Date

Consent for Use & Information Disclosure of Health Information

NAME OF PATIENT GIVING CONSENT _______________________________________

Address ____________________________________ City _____________ State _____ Zip _________

Telephone _______________________ SSN# _______-______-_______

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 options and activities, as well as health care options.

Notice of Privacy Practice

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 your protected heath 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 change. 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:

Office Manager

Telephone: 202-333-9282

Address: 730 24th Street Northwest Suite #9, Washington D.C. 20037

Email: info.dcdentalspa@gmail.com

Right to Revoke

You will have the right to revoke this Consent for Use and Information Disclosure of Health Information by giving written notice of your revocation submitted to the contact person noted above. Please understand the renovation of the consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Acceptance & Signature

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 consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare options.

Signature ____ Date ____________________________

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name ____

Relationship to Patient __________________________________

Financial & Office Policies

Insurance Policy

You will be informed of the **estimated** costs for any procedure that will be performed. You, as the patient, are ultimately responsible for the full amount incurred. We work with all PPO insurances; as a courtesy to our patients, we will file all the necessary paperwork to the insurance company and provide follow up if necessary. We accept payments from **some** PPO insurance plans. We Kindly remind you that your insurance policy is a contractual agreement between you and the insurance company. **DC Dental Spa is not a party to that contract.**

Usual and Customary Rates

Our dental practice is committed to providing the best treatment for our patients. Our prices reflect our commitment to the highest quality and utmost care.

Guarantee of Services

DC Dental Spa takes great pride in the quality of our work. All major treatments come with a 2-year warranty, commencing from the date the treatment was completed. Please note, the warranty is only applicable if the patient has adhered to the periodic re-care examinations and instructions recommended by the treating doctor.

Missed Appointments

In an effort to best accommodate all of our patients, all cancellations and rescheduling of appointments must be made 48 hours in advance and during business hours. In the event of a late cancellation, (less than 48 business hours notice) DC Dental Spa will charge a late cancellation fee of $75 for all hygiene appointments, and $250 for all procedural appointments that are over an hour long. This will ensure that you will receive 100% of the doctors' time and attention.

Collection Accounts

Only utilized as a last resort, collection procedures shall be implemented for past due accounts which will include a 33.33% collection fee. Please discuss your balance and payment options with our financial coordinator. If it becomes necessary to forward your account to a collection agency, you will be responsible for all accrued applicable interest, collection fees, and possible attorney fees.

Thank you for reading our Financial & Office Policy form. Please let us know if you have additional questions or concerns regarding these policies.

I have read the above and I understand and agree to the terms and conditions of this Financial & Office Policy.

Print Patient Name ______________________________________

Patient's Signature ______________________________________ Date ____________________________

Doctor-Patient Arbitration Agreement

The doctor ("Doctor") and the undersigned patient ("Patient") have agreed:

Article 1: Agreement to Arbitrate

The parties to this agreement are Doctor and Patient. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration and not by a lawsuit or resort to court process except as state law provides for judicial review or arbitration proceedings. **BOTH PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAE ANY SUCH DISPUTE DEIDED IN A COURT OF LAW BEFORE A JURY AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION.**

Article 2: All Claims Must be Arbitrated

It is the intention of the parties that this agreement bind all parties whose claims may arise out of the related treatment of services provided by the Doctor including any spouse or heirs of the Patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim in the case of any pregnant mother. The term "Patient" herein shall mean both the mother and the mother's expected child or children.

THE SOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE BY BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The parties hereby agree that they shall submit their controversy to an Arbitrator who is a dentist licensed in the state of ____________________.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the Doctor and the Doctor's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the Doctor to collect any fee from the Patient shall not waive the right to compel arbitration of any medical malpractice claim. However, following the assertion of any claim against the Doctor, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law

A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within third (30) days thereafter. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in any court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

Article 4: Payment of Arbitration Costs

The prevailing party in any arbitration pursuant to this agreement shall be awarded all costs, including reasonable attorney's fees and the arbitrator's fees, in prosecuting or defending the claim in arbitration, but not to exceed, $2500 in amount. Furthermore, if any action is undertaken to set aside or otherwise attack the binding arbitration award, the losing party in the court action shall bear all the prevailing party's costs, including reasonable attorney's fees.

Article 5: Future Services

This agreement shall govern all future services rendered to Patient by Doctor and Doctor's Partners, Affiliates and Associates. Execution of this agreement is a precondition to the furnishing of services by Doctor,

but this agreement may be rescinded by written notice by either party within thirty days of signature. After those thirty days, this agreement may be changed or revoked only by a written revocation signed by both parties.

IT IS UNDERSTOOD BY THE PATIENT THAT HE OR SHE IS NOT REQUIRED TO USE THE UNDERSIGNED DOCTOR AND THAT THERE ARE NUMEROUS OTHER DOCTORS IN THE IMMEDIATE AREA WHO ARE QUALIFIED TO PROVIDE THE SAME SERVICES.

Article 6: General Provisions

All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable state statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 7: No Other Representations

Except for the fact that the Doctor has indicated professional services will not be rendered to Patient unless the agreement is executed, the Doctor has made no other representations or statements, oral or written, to induce patient to execute this agreement.

Article 8: Revocation

This agreement may be revoked by written notice delivered to the Doctor within 30 days of signature and if not revoked will govern all medical services received by the patients.

Article 9: Retroactive Effect

If a Patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) Patient should initial below.

Effective as of the date of first Doctor Services

____
Patient's Initials

If any provision of the Doctor Patient Arbitration Agreement is held invalid unenforceable, the remaining provisions shall remain in full fore and halal not be affected by the individuality of any other provision.

THIS IS A BINDING LEGAL DOCUMENT WHICH MAY HAVE AN IMPORTANT EFFECT ON YOUR LEGAL RIGHT. CONSULT YOUR ATTORNEY ON ANY QUESTIONS YOU MAY HAVE.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUEE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

____
Name of Doctor

____
Doctor's Signature or Authorized Representative — Date

____
Translated By (If applicable): Print Name — Date

____
Signature of Translator — Date

____
Print Patient Name — Date

____
Patient's Signature — Date

____
Signature of Patient's Agent or Legal Representative — Date

____
Relationship to Patient