Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date:_____
☐ Male ☐ Female Last First MI

Email Address:_____ ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Handle Me With Care

- ☐ I gag easily
- ☐ I feel out of control when I am lying down in the dental chair
- ☐ I have not been to the dentist for a long time and I feel uncomfortable about what he will say or think about my teeth and my dental hygiene
- ☐ I know I have bad habits that are causing harm to me dental health. I am afraid I might not be able to break them
- ☐ Paine relief is a top priority to me
- ☐ I don't like shots, or I've had a bad reaction to shots
- ☐ Please tell me what I need to know about my mouth so I can make an informed decision
- ☐ My teeth are very sensitive
- ☐ I don't like the sound of that tool that makes the picking and scraping noise
- ☐ I don't like cotton in my mouth
- ☐ I hate the noise of the drill
- ☐ Please respect my time. I don't want to be left sitting in the reception area
- ☐ I want to know the cost up front. No money surprise, please
- ☐ I have difficulty listening and remember what I hear while sitting in the dental chair
- ☐ I have health problems and questions that we need to discuss
- ☐ I don't like being left alone in the treatment area
- ☐ I have problems with my back
- ☐ I don't like the chair tipped back too far
- ☐ I don't like to see the dental instruments
- ☐ I need to talk to you first, without sitting in the dental chair
- ☐ Other concerns I would like to talk about (please specify)

_____
_____
_____
_____
_____
_____

Revised 05/2018

Hal M. Lippard, D.D.S.
505 Faulconer Drive, Suite 1D
Charlottesville, VA 22903
(434)-293-9311

Notice of Privacy Practices

Patient Name_____ Date of Birth_____

I have received the practices Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization
- A description of uses and disclosures that are prohibited or materially limited by law
- A description of uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights on relation to:
    - The right to complain to this practice's HIPPA office (434-293-9311) and to the Secretary of HIPPA. If I believe my private rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to requested restrictions
    - The right to receive confidential communications of protected health information
    - The right to inspect and copy protected health information
    - The right to amend protected health information
    - The right to receive an accounting of disclosures of protected health information
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request

This practice reserves the right to change the terms of it's Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature_____ Date_____

Relationship to patient (if signed by a personal representative of patient): _____

Revised 05/2018

Office Protocol

Welcome! We are pleased that you have chosen Dr. Hal and his team for your dental care. Please find below out practice policies and procedures. We request you read, sign and date. If you need additional information or have questions please call the office and any of our staff will be happy to assist you.

Health History: We are a medical practice and as such we will ask you for annual updates of your personal and medical history. This information is very important to your care and your cooperation is appreciated.

HIPPA: To comply with the Health Insurance Portability and Accountability Act, we ask that you read, sign, and date our HIPPA compliance form.

Hours of care: Monday through Thursday 8:30 am. to 5:00 pm., Friday, from 8:30 am. to 12:00 pm. The after hours emergency number can be obtained by calling the office at 434-293- 9311. Please leave a message and an on-call staff member will contact you.

Appointments: As a courtesy, you will receive a reminder call for your appointment 48 hours prior to that time. We request that you confirm this appointment but if you must Make a change; please make every effort to give us 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient who may need it. We also reserve the right to charge a missed appointment fee if notification of such is not provided by COB the day preceding your appointment.

Insurance: We will file electronic insurance claims the same day of your appointment. We are an unrestricted out of network provider with all insurance plans. We are a preferred provider for the following; Anthem BCBS, Cigna, Delta, and United Concordia. If you have insurance that only pays directly to you, we will expect payment in full at time of service.

Methods of payment: All family members will be carried on the same account unless you request separate accounts. We accept cash, check, Visa, MasterCard, Am Ex, and Discover. Healthcare financing is available through Care Credit. This line of credit offers no interest with very affordable payments to qualified persons.

Thanks again for choosing our practice! We look forward to meeting you at your first visit.

Signature _____ Date _____

Revised 05/2018

Cancellation, and No Show Policy

We strive to offer a variety of convenient appointment times for all of our patients five days a week, including early morning and evening appointments. In order to effectively serve all of our patients, we have developed a Cancellation and No Show policy. We offer email and text confirmations to serve as a reminder of these appointments. If you are unable to keep your scheduled appointment times, we ask you to give our office as much advanced notice as possible. However, for those patients who no-show or cancel their appointment with less than 24 hours, the policies are as follow:

Hygiene Appointment Policy:

An appointment cancellation with less than 24 hours' notice will result in a $50 fee that must be paid prior to rescheduling

A no-show for a new patient will result in a full balance pre-payment of your next appointment before you are allow to rescheduled. Your insurance company will then need to reimburse you directly.

A no-show for an existing patient will result in a $50 fee that must be paid prior to rescheduling.

Dentist Appointment Policy:

An appointment cancellation with less than 24 hours' notice or a no-show will result in a fee of up to $100 depending on the type of your scheduled appointment. In addition, the patient must pay their portion of the treatment estimate prior to rescheduling the appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived, but only with Management approval.

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

_____ **Date of birth**_____

Patient Name (Please Print)

_____ _____

Signature of Patient **Date**

Revised 05/2018

General Consent For Dental Treatment

I understand the purpose of this general consent is to raise my awareness of risks that are common-place in many dental procedures. I understand my dentist reserves the right where appropriate (for example: for root canal therapy, extractions and other oral surgery, treatment of gum disease, placement or restoration of implants, crown, bridges, and dentures) to provide me with a more specific informed consent discussion.

I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian for a patient I should understand what treatment is being proposed, what the possible complications and risks are and what the alternatives are to the treatment. Of course, one alternative for me is to do nothing, although that carries with it its own risks.

My signature below confirms that I understand that no dental treatment is completely risk free and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that some after-treatment effects and complication tend to occur with regularity. For routine fillings, dental cleanings, prescription of medications, I understand this includes but is not limited to: temporary soreness, temperature sensitivity, unusual reaction/allergy to medications given or prescribed. Also, medications have common side effects that are listed by manufacturer. Further, if I am taking other medications, my dental medications could have an adverse interaction, and I need to fully disclose all of my medications to the dentist, dental hygienist, dental assistant and pharmacist. This includes herbal supplements.

For the administration of local anesthetic, I understand that for many treatments and procedures I will be given a local anesthetic injection and that in certain percentages of cases patients have had an allergic reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. For oral surgery, I understand that there is always a risk of post operative infection, nerve damage and iatrogenic injury. In rare cases, the complications from surgery can be permanent, disabling, or even cause death. I understand the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I understand that all treatments and procedures have a risk of separation of dental instruments, which may become lodged in a gum or other soft tissue or aspirated. Should I experience any of these or other conditions during or following treatment, I will contact Dr. Lippard as soon as possible.

I understand the practice of dentistry is not an exact science and my dentist offers no guarantees or assurance as to the outcome or results of treatment of surgery.

I have the right to ask Dr. Lippard for more information if I have any concerns about my procedures and the possible side effects or complications. I promise to use that right to its fullest intent if for any reason I feel I am not fully informed about my procedure, the risks or alternative to the procedure.

Patient Signature of Consent to treatment.

Signature: _____ Date: _____

Revised 05/2018