Fredericksburg Dental Artists

New Patient Registration Form

Yosreldin Koheil DDS FIOCI FAGD
10040 Jefferson Davis Highway Suite 112
Fredericksburg, Va 22407

Date _____

Patient Information

Last Name_____ First Name_____ Middle Int_____
Date of Birth_____ Sex M / F Social Security #_____
Employer_____ Occupation_____

What is the best method for contact? Please provide two ways for us to reach you:

Home Phone_____ Work Phone_____ Cell Phone_____
Do you prefer text message? Y / N Email_____

Address_____ Apt/Unit_____
City_____ State_____ Zip_____

Emergency Contact _____Relationship_____
Phone Number_____

How did you hear about us? _____

Who can we thank for referring you? _____

Would you like for us to bill your insurance on your behalf?

Primary Insurance _____ Subscriber_____
Address_____ Subscriber Date of Birth_____
City_____ State_____ Zip_____ Payer ID #_____
Phone Number_____ ID#_____ Group #_____

Secondary Insurance _____ Subscriber_____
Address_____ Subscriber Date of Birth_____
City_____ State_____ Zip_____ Payer ID #_____
Phone Number_____ ID#_____ Group #_____

I authorize Fredericksburg Dental Artists to confirm my appointments, treatment and billing information via:

Cell Phone
Home Phone
Work Phone
Text message
Email
Any of the options

I authorize Fredericksburg Dental Artists to convey information about my health via:

Cell Phone
Home Phone
Work Phone
Text message
Email
Any of the options

I authorize Fredericksburg Dental Artists to contact me about events, special services or fund raising efforts via:

Phone Message
Text Message
Email
Any of the options
I opt out

Medical and Dental Questionnaire

Patient Name _____

Email _____

Date of Birth ____/____/_____

Mark your response to indicate if you have had any of the following diseases or problems.
Mark **don't know (DK)** if you are unsure whether you have had the disease or problem.
If you have a disease or problem that is not listed below, write the disease or condition in the space at the bottom of this form.

Physician's Name _____ **Physician's Phone Number:** _____

Physician's Address _____

Date of last physical examination: _____

Yes	No	DK		
☐	☐	☐	Any changes in your health within the past year?	
			Cardiovascular	
☐	☐	☐	High blood pressure	
☐	☐	☐	Angina (chest pain)	
☐	☐	☐	Heart attack	
☐	☐	☐	Irregular heart beat	
☐	☐	☐	Heart surgery	
☐	☐	☐	Heart failure	
☐	☐	☐	Damaged heart valve	
☐	☐	☐	High cholesterol	
☐	☐	☐	Heart infection	
☐	☐	☐	Stroke	
			Hematologic	
☐	☐	☐	Anemia	
☐	☐	☐	Sickle cell anemia	
☐	☐	☐	Abnormal bleeding	
			Respiratory	
☐	☐	☐	Asthma	
☐	☐	☐	Emphysema/bronchitis	
☐	☐	☐	Sleep apnea	
☐	☐	☐	Difficulty breathing	
			Endocrine	
☐	☐	☐	Diabetes	
☐	☐	☐	Thyroid problem	
			Renal	
☐	☐	☐	Kidney disorder	
☐	☐	☐	Dialysis	

Yes	No	DK		
			Immune	
☐	☐	☐	Past use of steroids	
☐	☐	☐	Delayed healing	
			Musculoskeletal	
☐	☐	☐	Arthritis	
☐	☐	☐	Artificial joint	
☐	☐	☐	Fibromyalgia	
☐	☐	☐	Lupus	
☐	☐	☐	Sjogren's Syndrome	
☐	☐	☐	Osteoporosis	
			Gastrointestinal	
☐	☐	☐	Acid reflux/GERD	
☐	☐	☐	Irritable bowel syndrome	
☐	☐	☐	Stomach ulcer	
			Hepatic	
☐	☐	☐	Liver disease	
☐	☐	☐	Jaundice	
☐	☐	☐	Hepatitis A B C	
			Neurologic	
☐	☐	☐	Epilepsy/seizures	
☐	☐	☐	Parkinson's Disease	
☐	☐	☐	Multiple sclerosis	
☐	☐	☐	Headaches	
			Skin	
☐	☐	☐	Hives or skin rash	
☐	☐	☐	Other skin lesions	
			Eyes/Ears	
☐	☐	☐	Glaucoma	
☐	☐	☐	Impaired vision	
☐	☐	☐	Impaired hearing	

Yes	No	DK		
			Mental Health	
☐	☐	☐	Bipolar disorder	
☐	☐	☐	Depression	
☐	☐	☐	Anxiety	
☐	☐	☐	Eating disorders	
☐	☐	☐	Sleep disorder	
☐	☐	☐	Dementia	
☐	☐	☐	Learning disorders	
			Infections	
☐	☐	☐	HIV positive/AIDS	
☐	☐	☐	Sexually transmitted disease	
			Allergies	
☐	☐	☐	Local anesthetic	
☐	☐	☐	Antibiotics	
☐	☐	☐	Aspirin/ibuprofen	
☐	☐	☐	Acetaminophen (Tylenol)	
☐	☐	☐	Codeine/narcotics	
☐	☐	☐	Metals	
☐	☐	☐	Latex	
☐	☐	☐	Other:_____	
			Other	
☐	☐	☐	Cancer	
☐	☐	☐	Cancer treatment	
☐	☐	☐	Nursing infant	
☐	☐	☐	Tobacco use	
☐	☐	☐	Alcohol use	
☐	☐	☐	Chemical dependency	
☐	☐	☐	Street/recreational/ illicit drug use	

Please list any disease, condition, or hospitalizations and surgeries that are not listed above.

_____

Please list any BLOOD THINNERS you are taking.

_____

Women Only

Are you pregnant? Y☐ N☐ DK☐ Taking birth Control Pills Y☐ N☐ Breast feeding Y☐ N☐

Patient Name: ____________________

Date of Birth ___/____/__________

Medication List

For use by dentist

Patient to fill out

Medication & Dose	Condition prescribed for	MM/YYYY started	Update section (enter date of change & the new dose of medication. If discontinued, enter D/C)		
			Date/Change	Date/Change	Date/Change

Dental Information

Yes	No	
☐	☐	Are you satisfied with the appearance of your teeth?
☐	☐	Are you satisfied with the function of your teeth?
☐	☐	Does food frequently get caught between teeth?
☐	☐	Do your gums often bleed while brushing?
☐	☐	Have you noticed loosening of your teeth?
☐	☐	Have you injured your head, neck, or jaw?
☐	☐	Do you have difficulty eating or swallowing?
☐	☐	Do you have a dry mouth?
☐	☐	Have you had a change in your ability to taste foods?

Yes	No	Problems of the jaw – Have you noticed:
☐	☐	Clicking of the jaw?
☐	☐	Pain (joint, ear, side of face)?
☐	☐	Difficulty opening or closing?
☐	☐	Difficulty chewing?

Yes	No	Oral habits: Do you:
☐	☐	Clench or grind your teeth?
☐	☐	Bite your lips or cheek frequently?

Yes	No	Have you had:
☐	☐	Orthodontic treatment (braces)?
☐	☐	Oral surgery?
☐	☐	Gum treatment?
☐	☐	Your bite adjusted?
☐	☐	A bite plane/guard or other appliance?

Yes	No	Do you currently have:
☐	☐	Dental pain?
☐	☐	Sores or swellings in your mouth?
☐	☐	A partial/full denture or dental implants?
☐	☐	Do you supplement your diet with fluoride?
☐	☐	Have you had any difficulty with dental treatment?

NEW PATIENTS

Date of last dental x-rays_____

How often do you brush your teeth? _____

How often do you floss?_____

Date of last dental treatment:_____

Date of last teeth cleaning:_____

Reason for today's dental visit?_____

Medications:

_____

_____

_____

_____

_____

To the best of my knowledge, the preceding information is complete and correct.

_____ _____

Signature – Patient (or parent/guardian if patient is under 18) **Date**

****

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	Doctor INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Fredericksburg Dental Artiste

HIPAA Acknowledgement

Yosreldin Koheil DDS FIOCI FAGD
10040 Jefferson Davis Highway Suite 112
Fredericksburg, Va 22407

Patient Name: DOB:

Acknowledgement of receipt of notice of privacy practices, consent/limited authorization & release form. You may refuse to sign this.

I, , have received a copy of this office's Notice of Privacy Practices.
(Please print name)

Signature: Date:

Please list any party who can have access to your health information:

Name:.....Relationship:.....

Name:.....Relationship:.....

Name: .....Relationship:.....

Please complete how you would like us to contact you from the following:

Please address me by:

First Name Only

Proper Sir Name

Other

Financial Policy

Fredericksburg Dental Artists provides insurance company billing as a courtesy to patients. Treatment plans may change and I will be responsible for the work done. The patient portion of a particular dental service is estimated and due at the time of service. This amount may be subject to adjustment after receiving payment from the insurance company. Every effort will be made to help me with my insurance, but if they do not pay as expected, I, as the patient am responsible for any charges not covered by insurance. Fredericksburg Dental Artists accepts cash, checks, Visa, MasterCard, Discover and Care Credit. Please understand that any payment returned due to non-sufficient funds will be subject to a NSF fee of $25. I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due. If sent to collections, I agree to pay all related fees and court costs. Appointment times are very important and time has been reserved exclusively for me. I agree to give at least 48 hours notice for cancelled or rescheduled appointments. I agree to pay a fee of $50 for any appointment broken with less than 24 hours notice. I understand this will be at the discretion of Fredericksburg Dental Artists.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature: _____ Date: _____

Fredericksburg Dental Arts

Informed Consent

Yosreldin Koheil DDS FIOCI FAGD
10040 Jefferson Davis Highway Suite 112
Fredericksburg, Va 22407

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. Although these are often so seldom as to offset the benefits of treatment, they should be considered when making treatment decisions. Please review and initial for the following:

1. EXAMINATIONS AND X-RAYS I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. Initials _____

2. CHANGES IN TREATMENT PLAN I understand that during treatment it may be necessary to change or add procedures based on conditions found while working on the teeth not originally discovered during examination. I give the Dentist permission to make any/all changes and additions necessary after being explained to me. Initials _____

3. DRUGS, SEDATION AND MEDICATION I have been informed and understand that some drugs, sedation and medication may trigger allergic or sensitivity reactions. These may include swelling or sensitivity in tissue or gums, pain, itching, vomiting. In rare instances local anesthetics can result in transient permanent numbness or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. I understand that failure to take medications as prescribed for me may offer risks of continued or aggravated infection, pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). Initials _____

4. DENTAL PROPHYLAXIS (CLEANING) I understand that this treatment involves the removal of plaque and calculus above the gum line and will not address infections below the gum line called periodontal disease. I understand that bleeding may occur and could last several hours. If it is severe, or if it persists, I understand that it should receive attention and I will inform the office. Initials _____

5. PERIODONTAL TREATMENT I understand that I have a serious condition causing gum inflammation and/or bone loss that can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc). Alternative treatment plans have been explained to me and I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand that periodontal disease may have a future adverse effect on long-term success of dental restoration work. Initials _____

6. FILLINGS I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. THis may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that sensitivity is a potential risk with new restoration. Initials _____

7. ENDODONTIC TREATMENT (ROOT CANAL) I realize that there is no guarantee that root canal treatment will save my tooth. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle, a crown is necessary to strengthen and preserve the tooth. I understand that additional surgical procedures may be necessary following root canal therapy. I understand that the tooth may be lost in spite of all efforts to save it. Initials _____

8. DENTURES - COMPLETE OR PARTIAL I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture will be the "teeth in wax" try-in visit. Immediate dentures may be uncomfortable at first and may require several relines and adjustments. A permanent reline or second set of dentures will be necessary later and is not included in the initial denture fee. I understand that most dentures require relining approximately 3-12 months after initial placement and the cost is not included in the initial denture fee. Initials _____

9. BLEACHING Bleaching is a procedure done either in office or with take-home trays. The degree of whitening varies with the individual, with the average patient achieving considerable change (1-3 shades on the dental shade guide). Coffee, tea, and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity which may subside when treatment is discontinued. Pregnant women are advised to consult with their physician before starting treatment. Initials _____

10. TEMPOROMANDIBULAR JOINT DISORDER (TMJ) I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) following routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, I will be referred to a different healthcare provider, the cost of which will be my responsibility. Initials _____

We follow procedural guidelines which most often lead to clinical success. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.