Maryam Avin, D.D.S.
19366 Diamond Lake Drive Leesburg, VA 20176
703.687.3255

Patient Information

Patient Name: _____ Birth Date: _____
Last First

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

Social Security: _____ Email Address: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Street Apartment # City Zip Code

Employer Name: _____ Occupation: _____

Whom may we thank for referring you to our practice? _____

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
☐ Depression
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ 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
☐ Thyroid Problem
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Latex Allergy
OTHER:
_____
_____

List medications Prescription & Non-Prescription : _____

_____

Do you have any problems related to snoring and TMJ? If yes, please explain:

_____

Are you now under the care of a physician? If yes, please explain:

_____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? Yes No If yes, explain:

_____

Have you ever had any complications following dental treatment? Yes No If yes, please explain:

_____

Emergency Contact: _____Phone: _____

To the best of my knowledge, all 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.

X_____ Date: _____

Signature of Patient / Responsible Party

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Responsible Party Information

☐ **Same as patient**

Name: _____ Social Security: _____ Birth Date: _____
Last First

Phone - Home: _____ Work: _____ Other: _____

Insurance Claim Information

To process insurance claims on your behalf, we require the subscriber's Social Security number. **Without this information, full payment may be requested at the time of service, and we will assist you with the necessary documentation to submit to your insurance for reimbursement.**

Subscriber Name: _____ **Social Security:** _____ Birth Date: _____
Last First

Financial Policy

Thank you for choosing us as your dental care provider. We are committed to the success of your oral health.
We ask that you realize that we don't work for insurance companies, but we do work 100% for our patient.
Most insurance companies provide great benefits for our patients and we're going to do everything we can to maximize your benefits.
So please understand that the fees that we charge and the treatment that we're going to recommend
is specifically designed for your individual needs and never based on your insurance coverage.

Our Fees and Payment

Your co-payment and deductible are due at the time of service. To accommodate you we accept cash, check, Visa, MasterCard, Amex, Discover and CareCredit. For extensive treatment plans we offer flexible payment options, however, arrangements must be set up prior to appointment. Any appointments one hour or longer will **require one-third deposit to reserve the appointment time**. All returned checks will be charged a fee of $45.00.

Insurance Policy

On the day of your procedure your **full co-payment and deductible are due.** We will gladly submit the claims on your behalf; it is your responsibility to inform us of any changes to your insurance plan or benefits. We will try to assist you with your benefits, however knowing your benefits is your responsibility and all co-payments are an **estimate** of your benefits only. The estimate is never a guarantee of benefits or the amount that will be paid. If your insurance does **not** cover, deny, or does not make payment within 90 days the remaining balance is **your responsibility**. Due to the large volume of patients that we care for, we are unable to make frequent calls to your insurance carrier on your behalf. Please note that your dental insurance company may give an alternative benefit on composite (white) fillings and all ceramic crowns on posterior teeth. As a result, your out-of-pocket cost may be higher than initially estimate. Additionally, we routinely apply desensitizer to each treated tooth. This helps reduce and prevent tooth sensitivity and bacterial leakage. Please be aware that this treatment is not covered by most dental insurance plans and will be an additional cost.

Missed and Cancelled Appointments

Please consider your calendar carefully when scheduling an appointment. We require **48** hours' notice to change or cancel your appointments. There may be a $65 fee per hour for all missed, cancelled, or changed appointments.

X_____ Date: _____

Signature of Patient / Responsible Party

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Collection Accounts

Please note that if your account remains unpaid for a period of 30 days, interest at 1.5% will be applied per month and a one-time charge of **$45 for delay and unpaid balances**. If your account is sent to collections, you will be responsible for **all costs** involved with the collections process, which includes all court costs, attorney fees and finance charges. Your signature below indicates that you have read and agreed to our financial policy. Thank you for being a valued patient.

Your First Visit

Your initial first visit involves getting to know you, the problem you are experiencing and your dental needs. If you do not have any up-to-date copies of your dental records and X-Ray from your previous dentist; we will be taking full mouth X-Rays, photos and wellness scan to have an overview of your oral health. An overview of your mouth and gums will be followed by an oral cancer screening, then a thorough cleaning and polishing of your teeth. We will clean your teeth manually with traditional tools or use an advanced water powered instrument based on what is best for your specific needs. Fluoride treatments are recommended by the ADA for adults as well as children. After your initial appointment and reviewing your X-Rays, a treatment plan will be initiated. This will give you an idea of what type of treatment you may need, the cost, and any insurance coverage.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during the examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions as necessary.

I authorize Avin Dental Care, to take photographs, and/or videos of my jaws and teeth (No face), before, during and after treatment. I consent to allow the photographs or videos to be used for the following:

☐ Social media (Facebook, Instagram, Google) marketing material including websites and printed materials
☐ I refuse to share.

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:
• Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
• Obtain payment from third-party payers.
• Conduct normal healthcare operations such as quality assessments and physician certifications.

I authorize this information may be released to:

☐ Spouse ☐ Child(ren) ☐ Other ☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Patient Communication Consent

I consent to receiving communications from Avin Dental Care via text message, email, and phone calls, including automated messages. I understand these messages may include reminders for appointments, pending treatments, care coordination, and occasional practice promotions.

I understand: Standard message and data rates may apply. I may opt out at any time by contacting the office.

X_____ Date: _____

Signature of Patient / Responsible Party

STOP-BANG Sleep Apnea Questionnaire

Name: _____ Male / Female

Height: _____ Weight: _____ Age: _____

STOP

S	So, you **snore** loudly (louder enough to be head through closed doors or louder than talking)?	Yes	No
T	Do you often feel **tired**, fatigued or sleepy during the daytime?	Yes	No
O	Has anyone **observed** you stop breathing or choking or gasping during your sleep?	Yes	No
P	Do you have or are you being treated for high blood **pressure**?	Yes	No

BANG

B	**BMI** more than 35?	Yes	No
A	**Age** – over 50 years old?	Yes	No
N	**Neck** circumference – is it greater than 17” if you are male or 16” if you are female?	Yes	No
G	**Gender** – are you a male?	Yes	No

Epworth Sleepiness Scale

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven’t done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can. Use the following scale to choose the most appropriate number for each situation.

	Would never nod off 0	Slight chance of nodding off 1	Moderate chance of nodding off 2	High chance of nodding off 3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (e.g., in a meeting, theater, or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				