McQuiston Dental, Scott A McQuiston, DDS,

5350 Shawnee Road, Suite 310
Alexandria, Virginia 22312
(703) 354-0111

Welcome to our practice! We appreciate your selection of our office to serve your dental care needs. Our goal is to provide the very best possible dental care for our patients so that each of our patients may achieve optimal dental health and maintain it throughout your lifetime. Our entire staff operates as a team and is dedicated to your needs. We take great pride in each staff member's training and experience.

OFFICE HOURS

Our office is open Monday through Thursday from 8:00 a.m. to 5:00 p.m. (closed between 1 p.m. and 2 p.m. for lunch). We are closed on Fridays. We are closed on most major holidays, and when the dentist and staff are attending continuing education programs.

The appointments you make are reserved especially for you. Please kindly provide us with a minimum of **twenty-four hours notice should you be unable to keep your appointment to avoid a broken appointment charge.**

FINANCIAL ARRANGEMENTS

In an effort to keep costs down while maintaining a high level of professional care, we have established the following payment guidelines for the use of our patients. Fees may be paid as follows:

1. Payment is expected the day services are rendered unless prior arrangement have been made **in advance** with the office manager for amounts over $300.00.
2. Payment of balance in full within ten days of receipt of statement. Statements are mailed on a monthly basis. There will be interest charged on balances remaining unpaid after ten days.
3. We accept **VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS**. We also offer Care Credit financing by calling 1-800-365-8295 directly.
4. Accounts outstanding more than sixty days from treatment date may have an interest rate of 1.5% per month or 18% per annum levied.
5. All major treatment involving a laboratory procedure will require an appropriate down payment.

INSURANCE

If you have dental insurance we will be happy to file claims and accept assignment of benefits if your insurance company accepts electronic filing. Our staff will assist you in completing and submitting your insurance forms for payment to you. Ultimately, the patient is responsible for the above financial arrangements**. Professional care is provided to you, our patient, not to an insurance company. Therefore, the insurance company is responsible to you, the patient and the patient is responsible to the dentist. We are an in network provider with DELTA DENTAL and CIGNA DENTAL ONLY.**

PATIENT REGISTRATION

Please complete the following confidential information by filling in each section in its entirety. We ask that you *kindly supply all phone numbers* and indicate the best way to reach you during regular business hours.

_____

Last Name First Name Middle Initial

Home Address City State Zip Code

Home Phone # / Work # Cell # ***(Please provide all numbers!)***

_____/_____/_____/_____

Date of Birth Age: Social Security# Email Address:

_____/_____/_____

Spouse's Name Your Occupation Employer:

_____/_____

Employer's Address Employer's Phone Number

DENTAL INSURANCE INFORMATION

_____/_____

Insurance Company Phone # for ***Providers***

Name of Insured_____ Their Relationship to You_____

Their DOB_____ Their Social Security #_____

Group #_____ ID #_____

Employer's Address and Phone_____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name_____Phone_____

Address_____

CLOSEST RELATIVE NOT LIVING WITH YOU

Name_____Phone_____

Address_____

State_____Zip Code_____

WHOM MAY WE THANK FOR REFERING YOU TO OUR OFFICE?

_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

CONSENT FOR TREATMENT/FINANCIAL POLICIES

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by my doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that I can ask for a full recital of possible complications from treatment.

3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I further understand that I can ask for a complete recital of any possible complications from the use of anesthetic agents.

4. I agree to be responsible for payment of all services rendered on my behalf and/or on my dependents' behalf. I understand that payment is due at the time of service unless other arrangements have been made in advance. In the event that payments are not received by the agreed-upon dates, I understand that a one and a half (1.5%) percent late charge (18% APR) may be added to my account. If required, I also understand that a check of my credit history may be done. **We are an in network provider with DELTA DENTAL and CIGNA DENTAL ONLY.**

5. I understand that if a third party is used to collect on a debt that I have failed to pay within thirty days of treatment date, unless previous financial arrangements have been made, a $35.00 collection recovery fee will be added to my account. I further understand that a fee of $25.00 will be added to my account for returned checks.

6. I understand that 24 hours notice is required for cancellation of an appointment or a charge will be made.

Patient's Signature_____
Date_____

Parent/Responsible Party's Signature_____
Relationship to Patient_____
Date_____

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Notice of Privacy Policy and HIPAA Compliance

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Dr. Scott A. McQuiston. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Dr. Scott A. McQuiston reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in above, I hereby specifically authorize disclosure of my protected healthcare information to the persons indicated below.

	Yes	No
Any member of my immediate family		
Spouse only		

NOTICE OF "DEEMED CONSENT" TO BLOOD TESTING IN BLOODBORNE PATHOGEN EXPOSURE INCIDENTS

As healthcare providers we are required by s32.1-45.1 of the Code of Virginia, as amended, to give you the following notice.
If one of our healthcare professionals, workers or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV), Hepatitis B (HBV), and Hepatitis C (HCV). A physician or other healthcare provider will tell you the result of the test.
If you should be directly exposed to blood or body fluids of one of our healthcare professionals, workers or employees in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), Hepatitis B (HBV), and Hepatitis C (HCV). A physician or other healthcare provider will tell you and that person the result of the test.

I understand and consent to both notices as they have been described above.

_____ _____
Name of Patient or Representative **Signature of Patient or Personal Representative**

_____ _____
Date **Description of Personal Representative's Authority**