WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: ____________

E-Mail Address: ____________

Name: ____________
Last First MI Mr Mrs Ms Dr

I prefer to be called: ____________ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ___ SS#: ____________

Home Address: ____________ Apt/Condo #

____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)________ Pager / Cell #: ____________

Wk #: (____)________ Ext: ____ DL #: ____________

Employer: ____________

Employer's Address: ____________

How long there? ______ Occupation: ____________

Where & when are best times to reach you? ____________

Whom may we Thank for referring you? ____________

Other family members seen by us: ____________

Previous / Present Dentist: ____________
(Please Circle)

Last Visit Date: ____________

2 SPOUSE INFORMATION

His / Her Name: ____________

Employer: ____________

Wk #: (____)________ Ext: ____ SS #: ____________

Birthdate: ___/___/___ DL #: ____________

Person Responsible for Account: ____________

Wk #: (____)________ Ext: ____ Hm #: (____) ________

Billing Address: ____________

Relationship: ____________ SS #: ____________

Employer: ____________ DL #: ____________

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: (____)____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ___/___/___ Insured's ID #: ____________

Insured's Employer: ____________

Employer's Address: ____________

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: (____) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ___/___/___ Insured's ID #: ____________

Insured's Employer: ____________

Employer's Address: ____________

Neighbor or Relative not living with you.

His / Her Name: ____________ Relation: ____________

Wk #: (____)________ Hm #: (____) ________

Address: ____________

____
City State Zip

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________

Phone #: (____)________ Date of last visit: ________

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____________

CONTINUED ON BACK

4 MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: ______

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: ______

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y N Abnormal Bleeding
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis / Paget's Disease
Y N Pacemaker
Y N Psychiatric Treatment
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

______

______

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/materials that you are allergic to: ______

______

5 DENTAL HISTORY

Why have you come to the dentist today? ______

______

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ **Yes** ☐ **No**

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? ______ a day do you brush? ______

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? ______

Are your teeth sensitive to heat, cold, or anything else? ______

Have you lost any teeth? ☐ Yes ☐ No If yes, why? ______

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

______
Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

______
Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: ______ Date: ______

Doctor's Comments: ______

______

MEDICAL HISTORY UPDATE

I have read my medical history dated ______ and confirmed that it states past and present medical conditions. ______
Signature Date

I have read my medical history dated ______ and confirmed that it states past and present medical conditions. ______
Signature Date

I have read my medical history dated ______ and confirmed that it states past and present medical conditions. ______
Signature Date

WELCOME

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Today's Date: ______________________

Child's Name: ______________________
LAST FIRST MI

Nickname: ______________________ ☐ Male ☐ Female

Child's Birthdate: ____/____/____ Child's Age: __________

School: ______________________ Grade: ______

Child's Home #: (____)__________ SS #: __________

E-mail Address: ______________________

Child's Home Address:

______________________ APT/CONDO #

____
CITY STATE ZIP

Who Is Accompanying The Child Today?

Name: ______________________ Relation: __________

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? ______________________

Other family members seen by us: ______________________

____

Previous / Present Dentist: ______________________

Last Visit Date: ______________________

Parent's Marital Status: ☐ Single ☐ Widowed ☐ Partnered ☐ Married ☐ Divorced ☐ Separated

☐ Mother's Information: ☐ Step Mother ☐ Guardian

Name: ______________________ Birthdate: ___/___/___

Email Address: ______________________

Hm #: (____)__________ Cell #: (____)__________

Employer: __________ Wk #: (____)__________

SS #: __________ DL #: __________

☐ Father's Information: ☐ Step Father ☐ Guardian

Name: ______________________ Birthdate: ___/___/___

Email Address: ______________________

Hm #: (____)__________ Cell #: (____)__________

Employer: __________ Wk #: (____)__________

SS #: __________ DL #: __________

Person Responsible For Account

Name: ______________________ Relation: __________

Billing Address: ______________________

____
CITY STATE ZIP

Hm #: (____)__________ DL #: __________

Employer: ______________________

Wk #: (____)__________ Ext: ____ SS #: __________

Who is responsible for making appointments?

Name: ______________________

Wk #: (____)__________ Ext: ____ Hm #: (____)__________

Primary Dental Insurance

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone #: (____)__________

Group # (Plan, Local, or Policy #): ______________________

Policy Owner's Name: ______________________

Relationship to Patient: ______________________

Policy Owner's Birthdate: ___/___/___ ID#: __________

Policy Owner's Employer: ______________________

Employer's Address: ______________________

Orthodontic Coverage? ☐ Yes ☐ No

Secondary Dental Insurance

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone #: (____)__________

Group # (Plan, Local, or Policy #): ______________________

Policy Owner's Name: ______________________

Relationship to Patient: ______________________

Policy Owner's Birthdate: ___/___/___ ID#: __________

Policy Owner's Employer: ______________________

Employer's Address: ______________________

Orthodontic Coverage? ☐ Yes ☐ No

CONTINUED ON BACK

6 Why did you bring the child to the dentist today? ______________________

____

Has the child ever had a serious / difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does the child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: ______________________

Phone #: (____) __________ Date of Last Visit: __________

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health:
☐ Good ☐ Fair ☐ Poor

Has your child ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

Please list all drugs that the child is currently taking: ______________________

____

____

Please list all drugs/materials that the child is allergic to: ______________________

____

____

Latex? ☐ Yes ☐ No Metals/Nickel? ☐ Yes ☐ No Plastic? ☐ Yes ☐ No

7 Has the child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	ADD/ADHD	Y	N	Handicaps / Disabilities
Y	N	Allergies to any drugs	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Murmur
Y	N	Any Operations	Y	N	Hemophilia
Y	N	Artificial Bones / Joints / Valves	Y	N	Hepatitis
			Y	N	HIV+ / AIDS
Y	N	Asthma	Y	N	Kidney / Liver Problems
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Sickle Cell Disease / Traits
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)

Please discuss any serious medical problems that the child has had:

____

____

____

8 Does/did the child have any of the following habits?

Y	N	Lip Sucking / Biting	Y	N	Nursing Bottle Habits
Y	N	Nail Biting	Y	N	Thumb / Finger Sucking

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Neighbor or Relative not living with you.

Name: ______________________ Phone: (___) __________

Address: ______________________

____
CITY STATE ZIP

9

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____
Signature **Date**

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials: ______________ Date: ______________

Doctor's Comments: ______________________

____

____

____

____

Medical History Update

1. Date: ________ Signature: ______________

Comments: ______________________

____

2. Date: ________ Signature: ______________

Comments: ______________________

____

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Authorization for Release of Information

Name of Patient___________________________

Date of Birth_______________

Jack Mavromatis, D.D.S. is authorized to release protected dental information about the named patient to the entities described below. The purpose is to inform the patient or others in keeping with the patient's instructions. Please check the appropriate boxes below to authorize Jack Mavromatis, D.D.S. to discuss/ disclose your dental information related to billing, results of dental exams, x-rays and reports to the following:

Spouse - provide name____

Parent/Guardian- provide name(s) ___________________________________

Other - provide name____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected dental information to be disclosed as described in this document.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Patient Signature ____________________________________ Date __________

Jack Mavromatis, DDS
2248 Sunstates Court, Suite 103
Virginia Beach, Virginia 23451
757.496.9123
office@jackmavromatisdds.com

I, ________________________________ have received a copy of this office's Notice of Privacy Practices.

____

____

List names of children (under the age of 18) that will be included under this privacy agreement.

____

Signature (Parent of minor child, or Patient)

____

Date

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__________Individual refused to sign

__________Communications barriers prohibited obtaining the acknowledgement

__________An emergency situation prevented us from obtaining acknowledgement

__________Other (please specify)

____

____

____

JACK MAVROMATIS, D.D.S.
Family and Cosmetic Dentistry

Office Financial Policy

Our goal is to provide the best quality health care treatment available today. Following your diagnosis, Dr. Mavromatis will advise you of a treatment plan that will help you to maintain optimum dental health. Additionally, payment options will be discussed.

Payment is due at the time of services are rendered. We have several payment options for your convenience:

- Cash
- Check
- Mastercard, Visa, or Discover
- CareCredit Monthly Payment Plan**

** CareCredit applications are available at the front desk. CareCredit is a low monthly payment plan with no annual fees. CareCredit offers interest free payments up to a 18 months for qualifying amounts.

INSURANCE:

We will be happy to process your insurance claim, and *ESTIMATE* your deductible and portion not covered by the insurance (co-payment). The estimated amount not covered by your insurance is due at the time of treatment and may be paid by one of the above options. Our estimates are subject to final approval by your insurance company, therefore the amount due could change. If the insurance has not paid with 30 days you are responsible for any remaining balance.

INITIAL PAYMENTS:

Our office requires a deposit of one half at the start of major treatment (crowns, bridges, dentures, etc.) and payment in full once treatment is completed.

I understand that I am responsible for any interest, collection fees, legal fees, deductibles, and co-payments on my account and/or my family's account. If my insurance has not paid after 30 days, I am responsible for any remaining balances and finance charges that may occur.

24 HOUR NOTICE:

We require a 24 hour notice for cancellations. Our office charges a fee for broken appointments with out proper notification.

Signature of Responsible Party: ______________________________

Relationship to Patient: ______________________ **Date:** __________

2248 Sunstates Court, Suite 103 • Virginia Beach, VA 23451 • (757) 496-9123