Patient Name: _____

Patient Birth Date: _____

Referring Dentist: _____

Gavin M. Aaron, D.D.S., M.S.

Medical History Form

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.

Has there been any change in your general health during the last year?	◯ Yes ◯ No		
Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Has a dentist or physician ever told you that you had a tumor or cancer?	◯ Yes ◯ No		
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious illness, head, or neck injury?	◯ Yes ◯ No	If yes	
Have you ever had excessive bleeding following extraction of a tooth or from a cut?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Have you ever been told not to take novocaine?	◯ Yes ◯ No		
Do you use tobacco?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No	If yes	
Do you pre-medicate for dental visits?	◯ Yes ◯ No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medidne ◯ 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 Problems ◯ 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	Twitching of Limbs ◯ Yes ◯ No	Dizziness ◯ Yes ◯ No	Growing Pains ◯ Yes ◯ No
Severe Headaches ◯ Yes ◯ No	Foods You Can't Eat ◯ Yes ◯ No	Bladder Trouble ◯ Yes ◯ No	Syphilis ◯ Yes ◯ No
Had a Nervous Breakdown ◯ Yes ◯ No	Have Prosthetic Joints ◯ Yes ◯ No		

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

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:

X

Date:

PATIENT REGISTRATION

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name or Nickname: _____

Referred By (Dentist): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Sex: ○ Female ○ Male

Height: _____ Weight: _____

Birth date: _____ Social Security #: _____

E-mail: _____ ☐ I would like to receive email correspondences

INSURANCE INFORMATION

☐ *I Do Not Have Any Dental Insurance*

******If you do not have dental insurance please skip this section******

- Policy Holder (main name on the policy): _____
- Date of Birth of the Policy Holder: _____
- Name if the Insurance Company: _____
- Policy Group Number: _____
- Employer for Insurance: _____
- Subscriber/Member ID Number: _____
- Relationship to the Policy Holder if not you: _____

I authorize Dr. Gavin Aaron, D.D.S., M.S. or the practice to release any information in the course of my exam or treatment to my insurance company. Also, authorize payment directly to Dr. Gavin Aaron, D.D.S., M.S. or the practice for services rendered. **Any amount not paid by my insurance company is my full financial responsibility.**

Signature: _____ Date: _____

AARON
Periodontics & Dental Implants

OFFICE PAYMENT POLICY

Exam Procedures:

• Comprehensive full-mouth periodontal exam	$145.00
• Full-mouth series or panorex x-rays	$145.00
• Single Film(periapical radiograph/PA)	$20.00
• Each additional film (periapical radiograph/PA)	$10.00

Payment at Initial Exam (Consultation):

- For patients with **Delta Dental or Cigna Dental** insurance coverage, we provide in-network benefits.
- **For patients that have out-of-network insurance, payment is expected in full** and we will file with your dental insurance on your behalf and have the insurance reimbursement sent directly to you.

Payment for Emergency Procedures:

- Payment is due in full for procedures performed at emergency exams.

Payment for Oral Biopsies:

- Payment is due in full for biopsies, as coverage by dental insurance is not likely. Also, there will be an additional fee charged to you by the oral pathology lab that handles the biopsy specimen.

Cancellation Policy:

- **Appointments cancelled without a 24 hour notice are subject to a $50.00 cancellation fee.**

INSURANCE POLICY

- **Dr. Aaron's staff will file insurance pre-estimates on your behalf prior to undergoing any procedures beyond the initial exam.**
  The pre-estimate normally takes 4-6 weeks to be processed. You will receive a written explanation of your estimated insurance coverage by mail from your insurance provider. Also outlined in the letter will be your **estimated** co-payment based on your insurance providers fee, which will be due at the time of service. **Should you not want to wait for the insurance pre-estimate, payment in full will be expected at the time of service**. From there, an insurance claim will be filed, and you will be reimbursed for any insurance payment.
- **Dr. Aaron is a Delta Dental and Cigna Dental provider, which means he accepts their fee structure**. Patients who do not have these insurances are expected to pay in full the cost for the initial consultation and any x-rays at the end of the appointment.

I have read and understand the financial policies outlined above and any questions regarding them have been answered in a satisfactory manner. **I understand that any unpaid balance by my insurance company is entirely my responsibility.**

- *Fees are subject to change without a notice.

Signature of Patient/Responsible Party: _____

Date: _____

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AARON
Periodontics & Dental Implants

CONSENT FOR USE AND DISCLOSURE

OF HEALTH INFORMATION

Section A: Patient giving consent

Name: _____

Address: _____

Telephone: (home) _____ (work)_____

Social Security Number: _____

Section B: To the patient- please read the following statement carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice of privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our notice of privacy practices, including any revisions of our notice at any time by contacting us:

Telephone: 540-562-3166 **Fax:** 540-562-0760

Address: 4405 Starkey Rd, Roanoke VA 24018

Right to Revoke: You will have the right to receive this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this consent form and your notice of privacy practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name: _____

Relationship to patient: _____