GYURICZA & HARTMAN
FAMILY & COSMETIC DENTISTRY

PATIENT REGISTRATION

Phone: _____
Cell: _____

Date: _____ (PLEASE PRINT) Email: _____

Patient: _____
(Last Name) (First Name) (Initial) (Preferred Name)

Street Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: ____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse Name: _____ Spouse Birthdate: _____

Spouse Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Social Security Number: _____ Spouse's Social Security Number: _____

Dental Insurance Company: _____ Group Number: _____

In case of emergency, who should be notified? _____ Phone: _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Physical: _____

Have you ever had any of the following? (Check boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Heart Murmur-Mitral Valve Prolapse
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ "A.I.D.S" or Other Immunosuppressive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any **drug allergies** or have you ever had an **adverse reaction** to any medication? _____ If so, what:

_____

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Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what: _____

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

For what conditions? _____

If the patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐No

Are you nursing? ☐ Yes ☐No

Is there anything else we should know about your medical history? _____

DENTAL HISTORY

Date of last dental exam? _____ Date of last full mouth series? _____

What is the reason for today's visit? _____

If there was a simple inexpensive way to whiten your teeth, would you be interested? _____

If you could wave a magic wand and change one thing about your smile, what would it be?_____

Why did you leave your last dentist? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have in the completion of this form.

Patient Name: _____ Signature: _____ Date: _____

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GYURICZA & HARTMAN

FAMILY & COSMETIC DENTISTRY

JAMES L. GYURICZA, D.D.S., F.A.G.D. & MELANIE WILSON HARTMAN, D.M.D.

CANCELLATION POLICY

It is our goal to keep our fees for our services as reasonable as possible. Our fee schedule is based on efficient scheduling and is dependent upon our patients arriving for their appointments in a timely fashion.

With this in mind, if you find you are unable to keep your appointment, we request that you give us at least 24 hours' notice. Otherwise, an $80.00 ($100 for evenings and Saturdays) fee will be charged for the missed appointment. This $80.00 ($100 for evenings and Saturdays) fee, which is not covered by dental insurance companies, will need to be paid prior to the time of you next appointment.

*__PLEASE NOTE__: If you miss three appointments, without prior 24-hour notice, our office will cancel the remainder of your appointments. We will place a courtesy call informing you of such action.

Thank you for your cooperation.

_____
Print Patient's Name

_____ _____
Patient/Guardian/Adult Signature Date

GYURICZA & HARTMAN

FAMILY & COSMETIC DENTISTRY

JAMES L. GYURICZA, D.D.S., F.A.G.D. & MELANIE WILSON HARTMAN, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices of the offices of Drs. James L. Gyuricza, D.D.S., F.A.G.D. and Melanie Wilson Hartman, D.M.D. The Statement of Privacy Practices describes the types of uses and disclosure 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 right and the responsibilities and duties of the office with respect to my protected information. The Statement of Privacy Practices is also posted in the facility.

James L. Gyuricza D.D.S., F.A.G.D and Melanie Wilson Hartman D.M.D reserve the right to change the privacy practices 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 the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person indicated below:		
ANY MEMBER OF MY IMMEDIATE FAMILY	☐**YES**	☐**NO**
SPOUSE ONLY	☐**YES**	☐**NO**
OTHER (PLEASE SPECIFY): PATIENT'S OFFICE ASSOCIATES & EMAIL	☐**YES**	☐**NO**

_____ _____

Name of Patient or Personal Representative Signature of Parent or Personal Representative

_____ _____

Date Description of Personal Representative Authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

PROVIDED PRIOR TO TREATMENT: ☐**YES** ☐**NO**	
DATE PROVIDED:	
REASON FOR DENIAL: ☐NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES	
☐WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING	
☐UNABLE TO SIGN	
☐REASON NOT GIVEN	
☐OTHER (EXPLAIN)	

JAMES L. GYURICZA, D.D.S., F.A.G.D. & MELANIE WILSON HARTMAN, D.M.D.

GYURICZA & HARTMAN FINANCIAL POLICES

Thank you for choosing Gyuricza & Hartman Family & Cosmetic Dentistry. We are committed to providing you with the best dental care possible.

INSURANCE: Your insurance policy is a contract between you, your employer and the insurance company. We make every effort to file insurance claims as a courtesy to our patients, but all charges are your responsibility from the date of service rendered. Not every service is a covered benefit under all contracts. It is important that you read and understand **YOUR** health insurance policy and its requirements for coverage including pre-authorization of services. We currently send claims to over 100 plans and are not responsible for knowing the requirements of your specific plan. If you provide outdated or incorrect insurance information, you will be responsible for any denied claims. Most plans have a timely filing period so it is important that the information you provide our practice is the most current available. If the insurance company does not pay your balance in full within 30 days, we will ask that you contact the carrier to assist with payment in a timely fashion. If the insurance company does not pay in full within 90 days, we will require you to pay the balance due with cash, personal check, Visa, MasterCard, or Discover Card.

SECONDARY INSURANCE: We do not file secondary insurance unless we are participating providers with your carrier. If you need a copy of the original claim for your secondary carrier, please call our office and one will be mailed to you. Please keep in mind that the secondary carrier pays only after the primary carrier has paid. A copy of the "Explanation of Benefits" from your primary carrier should accompany this claim.

PROCEDURES NOT COVERED BY INSURACE: All payments are due on the day of service.

PAYMENT: Payment for services rendered is due at time at time of treatment. We accept assignment of insurance benefits. However, you will be required to pay the portion of the service that we estimate will not be paid by the insurance company. All charges are your responsibility whether or not your insurance company pays. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We accept cash, checks, Visa, MasterCard, and Discover. There is a $35.00 returned check fee. Balances older than 60 days will be subject to our attorney for collection, you will be responsible for the cost of collection, to include court costs and attorney's fees actually incurred in the collection of your account.

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COPAYS, DEDUCTIBLES AND CO-INSURANCE: Per your insurance company, your copay must be paid at the time services are rendered. Deductible and co-insurance fees are due at time of services.

COPIES OF MEDICAL RECORDS: Our fee for this service is based on Virginia Code §8.01-413B, which requires that records be provided within 15 days for a charge not to exceed 50¢ per page for the first 50 pages and 25¢ for each additional page, and a fee not to exceed $10.00 for searching, handling and mailing records.

The above is a summary of our policies. Please do not hesitate to contact us with questions or concerns.

I acknowledge and represent that I have read the foregoing statement of Gyuricza & Hartman Family & Cosmetic Dentistry's Financial Practices, and that I understand and sign it voluntarily as my own free act and deed. I further acknowledge that no oral representations, statements, or inducements, apart from the foregoing written form, have been made.

_____
Print Patient's Name

_____ _____
Patient/Guardian/Adult Signature Date

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