MARK S. JEFFERIES, DMD, PLC
FAMILY & COSMETIC DENTISTRY

500 Grove Street :: Suite 303 :: Herndon, VA 20170 :: 703.793.1771

Welcome

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of HIPAA Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

☐ In Office Use Only
Individual Refused to sign

☐ Communication barrier prevented obtaining acknowledgement

☐ An emergency situation prevented obtaining the acknowledgement

Patient Information (Confidential)

Date_____ Referred by_____

Patient Name_____
Last First Middle

Birth Date_____ Social Security#_____Gender (M/F)_____

Marital Status (please check): Minor_____ Single_____ Married_____ Other_____

Home Address_____
Street

_____
City State Zip code

Email Address_____

Phone Numbers Home_____ Cell_____ Other_____

Employer Name_____Phone_____ext_____

Address_____
Street City State Zip

Emergency Contact Name_____ Phone_____

Spouse or Responsible Party Information

Name_____
Last First Middle

Birth Date_____ Social Security #_____ Gender (M/F)_____

Home Address_____
Street City State Zip

Phone Numbers Home_____Cell_____Other_____

Name_____

Insurance Information

Primary
Name of Insured_____ Relationship to Patient_____

SS#_____ Insured's DOB_____

Insurance Company (Name and Address)_____

_____

Insurance Phone_____ Fax_____

Insurance Group #_____ Policy ID/#_____ Effective Date_____

Secondary
Name of Insured_____ Relationship to Patient_____

SS#_____ Insured's DOB_____

Insurance Company (Name and Address)_____

_____

Insurance Phone_____ Fax_____

Insurance Group #_____ Policy ID/#_____ Effective Date_____

Cancellation Policy

We ask that at least 24 hours advance notice for canceling or rescheduling an appointment; otherwise, a $65 fee may be assessed to your account. Please understand that all Health Care Facilities have overhead expenses that must be managed. When appointments are missed there is a decrease in revenue to pay for expenses. This in turn drives up health care fees which affects everyone else. Please do your part and confirm and attend your Dental appointment or reschedule with at least 24hrs notice so we can fill your appointment slot.

Note: All cancellation fees must be paid prior to scheduling another appointment.

The treatment that is planned for you is specific to you. It is important to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people- the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.
Please sign that you read and understand our Cancellation Policy. Thank you!!

Signature_____ Date_____

Consent

I hereby authorize Dr. Jefferies and/or staff to take radiographs (x-rays), study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis.

I authorize the doctor to perform all recommended treatment mutually agreed upon. I also agree to the use of appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.

I understand that any medications prescribed can cause allergic reactions ranging from mild to severe .

During treatment it may be necessary to change or add procedures due to conditions found that were not originally observed during diagnosis.

I understand that anytime a restoration (filling, crown etc...) is performed ,whether large or small, there is a possibility of trauma to the nerve of the tooth. This could result in varying degrees of sensitivity and complications including but not limited to: sensitivity to hot and/or cold, bite changes, pulp necrosis any of which could require additional treatment.

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine. As stated in the "Payment Policy" form, payment is due and payable at the time services are rendered unless other arrangements have been made.

I understand that a fee will be assessed for any missed appointments at the day of expected service. Should I need to cancel or change any appointments, I understand that I need to give the office 24 hours notice.

I understand that it is my responsibility to advise this office of any changes in the information contained in this form.

Print Name_____

Signature_____ Date_____