STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Virginia. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone - even family members - without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights!

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at Drs. Levin, Leff, Pollock and Assoc., LTD. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.
Greater Washington Endodontics
(Formerly Drs. Levin, Leff, Pollock & Associates)

Signature Form for Statement of Privacy Practices

Office Locations:
Falls Church  Burke  Arlington  Reston
311 Park Ave.  8987 Hersand Dr.  3801 N. Fairfax St.  11710 Plaza America Dr.
Falls Church, VA  Burke, VA  Arlington, VA  Reston, VA
22046  22015  22203  20190

Woodbridge
12701 Marblestone Dr.
Suite 180
Woodbridge, VA
22192

I acknowledge receipt of the Statement of Privacy Practices from Greater Washington Endodontics.

Patient: ___________________________________ (Print)

Signature: __________________________________

Date: _____________________

www.va-rootcanal.com
PERMISSION FOR ENDODONTIC TREATMENT

This form will constitute your written consent for Greater Washington Endodontics to perform any necessary dental procedure(s) as indicated by our examination during root canal therapy such as occlusal adjustment, canal preparation by post, perforation repair or special instructions from the referring general dentist. As the patient you have been informed and understand that there are certain inherent and potential risks in any treatment procedure. These include swelling, bruising, discomfort, infection, permanent numbness or tingling of the lips and/or jaw. Fractures of existing restorations, the tooth, and/or instruments used to perform the treatment may occur. Additionally, variations in canal shape and size may complicate treatment and result in a perforation (hole) in the root or a root canal filing that is less than desirable.

If you are taking or have ever taken oral or intravenously administered bisphosphonates (Fosamax, Boniva, Adonel, Skelid, Didronel, Aredia, Zometa or Bonefos) to treat osteoporosis, Paget’s disease or cancer, you are at risk of developing osteonecrosis of the jaw for surgical procedures such as extractions and surgical endodontic therapy (root amputation or apicoectomy). Osteonecrosis is the death of the bone which can occur from loss of blood supply or inability of the bone to.regrow. The risk of developing osteonecrosis is higher if you are over 65 years old, take intravenously administered bisphosphonates, have periodontal disease, take oral glucocorticoids for chronic conditions.

For the patient, signature of consent and understanding:

_____ (Initials) I understand root canal therapy has a high degree of success. However, it is a biological dental procedure, and success cannot be guaranteed. Occasionally a tooth which has had a root canal may require further treatment, surgery or even extraction. I have been advised of possible alternative methods to endodontic treatment which include extraction and of adverse results from certain alternative treatments. Unless referred to this office for an additional procedure, I understand that the permanent restoration (filling or crown) will be done by my general dentist following the root canal therapy.

SIGNATURE: ___________________________________________ DATE: ________
(PATIENT/GUARDIAN)

DRS INITITIALS: ______________
PATIENT INFORMATION…

Mr. Mrs. Ms. Dr. First Name_________________________ M.I. ___ Last Name_________________________ Nickname ____________
Sex: ☐ Male ☐ Female Birth Date ___________ Age ______ Soc. Sec. # ___________________________ E-mail ______________________
Street ___________________________ Apt. _____ City_________________________ State ______ Zip ________
Home Tel. (______) ____________ Cell. (______) ____________ Have you ever been a patient of our practice? ☐ Yes ☐ No
Referred By ___________________________ Has a family member ever been a patient of our practice? ☐ Yes ☐ No
Referred By ___________________________ Personal Payment Type: ☐ Cash ☐ Check ☐ Credit Card

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT…

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other ___________________________
Name ___________________________ S.S.# ________ Birth Date _________ Age ______ Tel. (______) ________
Street ___________________________ Apt. _____ City_________________________ State ______ Zip ________
Driver’s Lic. # ___________________________ Employer ___________________________ Bus. Tel. (______) ________

SPouse OR OTHER GUARANTOR INFORMATION (if different from above)…

Name ___________________________ Relation_________________________ S.S.# ________ Birth Date _________
Street ___________________________ Apt. _____ City_________________________ State ______ Zip ________
Tel. (______) ________ Employer ___________________________ Bus. Tel. (______) ________

INSURANCE INFORMATION…

Student: ☐ Full Time ☐ Part Time ☐ Not ☐ School Name and Address ___________________________
Marital Status: ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated ___________________________
Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not ☐ Do you belong to a PPO or HMO? ☐ Yes ☐ No ___________________________

PRIMARY DENTAL INSURANCE COMPANY

Employer _____________________________
Bus. Address _____________________________
Bus. Tel. (______) ________ Plan _____________________________
Ins. Co. Name _____________________________ I.D. # _____________________________
Address _____________________________
State ___________ Zip ________
Group # ________ Group Name _____________________________
Insured Party First Name_________________________ Last Name_________________________ Relation _____________________________
Sex: ☐ M ☐ F Birth Date ________ S.S. # _____________________________
Street ___________________________ City ___________________________
State, Zip ___________ Tel. (______) ________

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____________________________
Bus. Address _____________________________
Bus. Tel. (______) ________ Plan _____________________________
Ins. Co. Name _____________________________ I.D. # _____________________________
Address _____________________________
State ___________ Zip ________
Group # ________ Group Name _____________________________
Insured Party First Name_________________________ Last Name_________________________ Relation _____________________________
Sex: ☐ M ☐ F Birth Date ________ S.S. # _____________________________
Street ___________________________ City ___________________________
State, Zip ___________ Tel. (______) ________

DENTAL INFORMATION…

Reason for today’s visit _____________________________ Are you in pain? ☐ Yes ☐ No, For How Long? _____________________________

Please indicate any of the following problems by checking off the corresponding box:

☐ Discomfort, clicking, or popping in jaw ☐ Lost / broken filling(s) ☐ Difficulty closing jaw
☐ Red, swollen, or bleeding gums ☐ Teeth grinding / clenching ☐ Difficulty opening jaw
☐ A removable dental appliance ☐ Ringing in ears ☐ Loose / shifting teeth
☐ Blisters / sores in or around the mouth ☐ Broken / chipped tooth ☐ Food caught between teeth
☐ Prolonged bleeding from an injury / extraction ☐ Gum disease ☐ Burning tongue / lips
☐ Recent infections or sore throat ☐ Other ☐ Toothache
☐ My teeth are sensitive to: ☐ Hot ☐ Cold ☐ Swelling / lumps in mouth
☐ Sweets ☐ Biting

Last dental exam ___________ Last dental x-rays ___________ Times a day you brush? ________ Times a week you floss? ________

How would you rate your smile? [worst] 1 2 3 4 5 6 7 8 9 10 [best] Would you like whiter teeth? ☐ Yes ☐ No

What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard
**MEDICAL HISTORY...**

Are you in good health?  ❑ Yes ❑ No • Height ___________ Weight ___________ • Are you under the care of a physician?  ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?  ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years?  ❑ Yes ❑ No

Have you ever had general anesthesia?  ❑ Yes ❑ No • Have you, or a family member, had any unusual or serious reactions to general anesthesia?  ❑ Yes ❑ No

**Do you have, or have you had, any of the following diseases, medical conditions, or procedures?**

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<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatic fever</td>
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<td>❑</td>
</tr>
<tr>
<td>High blood pressure</td>
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<td>❑</td>
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<tr>
<td>Low blood pressure</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Mitral valve prolapse</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Heart murmur</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Chest pain / Angina</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Heart attack(s)</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Irregular heart beat</td>
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<td>❑</td>
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<tr>
<td>Cardiac pacemaker</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Heart surgery</td>
<td>❑</td>
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<tr>
<td>Damaged heart valves</td>
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<td>❑</td>
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<tr>
<td>Pneumonia / Bronchitis / Chronic cough</td>
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<tr>
<td>Chronic fatigue / Night sweat</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Trouble climbing 1-2 flights of stairs</td>
<td>❑</td>
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<tr>
<td>Anemia</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Asthma</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Mental health problems</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Problems with immune system (possibly from med. / surg.)</td>
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<td>❑</td>
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<tr>
<td>Delay in healing</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Hay fever / Sinus problems</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Snoring / Sleep apnea</td>
<td>❑</td>
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<tr>
<td>Respiratory problems</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Emphysema</td>
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<tr>
<td>Do you smoke</td>
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<tr>
<td>A history of chewing tobacco</td>
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<td>❑</td>
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<tr>
<td>A history of alcohol abuse</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Abnormal bleeding</td>
<td>❑</td>
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<tr>
<td>Bleeding tendency</td>
<td>❑</td>
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<tr>
<td>Blood transfusion</td>
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<tr>
<td>Blood disorder</td>
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<td>❑</td>
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<tr>
<td>Bruise easily</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Eye disease / Glaucoma</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Jaundice / Liver disease</td>
<td>❑</td>
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<tr>
<td>Hepatitis</td>
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<td>❑</td>
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<tr>
<td>Gallbladder trouble</td>
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<tr>
<td>Fainting spells</td>
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<td>❑</td>
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<tr>
<td>Convulsions / Epilepsy</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Thyroid trouble</td>
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<tr>
<td>Diabetes</td>
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<td>❑</td>
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<tr>
<td>Low blood sugar</td>
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<tr>
<td>Are you on dialysis</td>
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<tr>
<td>Kidney trouble</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Sexually transmitted diseases</td>
<td>❑</td>
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<tr>
<td>Contagious diseases</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Infectious mononucleosis</td>
<td>❑</td>
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<tr>
<td>Swollen ankles</td>
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<tr>
<td>Arthritis / Joint disease</td>
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<tr>
<td>Prosthetic implant</td>
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<tr>
<td>Joint replacement</td>
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<tr>
<td>Osteoporosis / Osteopenia</td>
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<tr>
<td>Osteonecrosis</td>
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<td>Stomach ulcers</td>
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<tr>
<td>Tumor or growth</td>
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<tr>
<td>Cancer / Radiation / Chemotherapy</td>
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<tr>
<td>Are you on a diet</td>
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<tr>
<td>Contact lenses</td>
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</table>

**MEDICATION & ALLERGIES...**

**Are you now taking:**

- Nerve pills
- Diet pills
- Pain killers (including aspirin)
- Tranquilizers
- Muscle relaxers
- Insulin
- Stimulants
- Antidepressants
- Blood thinners

**Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):**

**Are you allergic to, or had a reaction to:**

- Penicillin
- Sulfas / Sulfa drugs
- Aspirin
- Soy
- Eggs / Yolk
- Local anesthetic (numbing med)
- Codeine or other narcotics
- Sulfites
- Latex
- Do you have any known allergies

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: (Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy?  ❑ Yes ❑ No

3) Are you nursing?  ❑ Yes ❑ No

2) Expected delivery date: ___________

4) Are you taking birth control pills:  ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

**FEES & PAYMENTS**

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs.**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

I hereby acknowledge that a copy of this office’s Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

**Signature of patient (Parent or Guardian if Minor)**

**Reviewed by**

**Date**