WILLIAM V. DOUGHERTY III, D.D.S.
PATIENT INFORMATION

Date _________________
Name (first, middle initial, last) ____
Sex: Male ____ Female ____
Please check one: Single ______ Married ______ Child ______ Other ______
Date of Birth __________________ Soc. Sec. # ____________________
Address: ____
City ______________________ State ______ Zip Code _____________
Home Phone: (_______) _________________
Work Phone: (_______) _________________
Optional: Fax ___________________ Pager _________________
Email ____

Employer: ____________________________________ Occupation: _________________
Address: ____
Referred by: Friend/Coworker______________________________________Sign _____
Insurance _____________ Other_________________

Name of Dental Insurance: ____
Name of Policy Holder: ____
Soc. Sec # of Employee __________________ Date of Birth ________________________
Relationship to Policy Holder: Self _____ Spouse ______ Parent _______
Policy Holder's Employer ____
Address of Ins. Co. ____
____

Phone Number of Ins. Co. ____
Individual ID# if different from SSN _________________________________
Group # ___________________ Policy Holder's Work Phone ______________________
Policy Holder's Address if different from above __________________________________
____

In case of emergency please list two contacts:
Name ___________________ Relationship ____________Phone ____________________
Name ___________________ Relationship ____________Phone ____________________

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 Dr. Dougherty or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: ___________ Signature: ____
(Patient or Guardian)

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with ______________________________, and assign
Name of insurance company(ies)
directly to Dr. Dougherty all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date: ____________ Signature: ____
Signature of Patient/Guardian

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Dr. Dougherty and/or the dental staff for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, maximums and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor I am responsible for the total amount(s).
I understand that because appointments are not double-booked, I must provide notice of cancellation at least 24 hours prior to my scheduled appointment time. **For any missed appointment a fee of thirty-five ($35) dollars will be assessed to my account for every fifteen minutes scheduled.** This fee covers the cost of office overhead during time set aside specifically for me or for my dependent(s).

I understand that for any treatment less than five hundred ($500) dollars payment in full is due at the time of service. Any payment plans* I agree to with this office must be completed. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney I agree to pay all collection and attorney fees.
*An 18% (eighteen percent) per annum finance charge is assessed to any account that is more than thirty days old.

Date: ____________ Signature: ____
Signature of Patient/Guardian

MINOR/CHILD CONSENT

I, being the parent or guardian of ___________________________, do hereby request and
Name of minor/child
authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (xrays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: ____________ Signature: ____
Signature of Patient/Guardian

MEDICAL HISTORY

Name of Physician ____________________________
Date of last physical exam ____________________________

Please indicate if you have ever had: (Please mark the appropriate column)	Currently	In the Past	Never Had
Anemia	☐	☐	☐
Asthma	☐	☐	☐
Diabetes,	☐	☐	☐
If currently diabetic, are you insulin dependant? Y N			
Tuberculosis	☐	☐	☐
Sinus Problems	☐	☐	☐
Fen/Phen or other prescription weight loss drugs	☐	☐	☐
Kidney Disease	☐	☐	☐
Hemophilia	☐	☐	☐
Radiation Treatment	☐	☐	☐
Cancer	☐	☐	☐
High Blood Pressure	☐	☐	☐
Heart Attack, Heart Surgery or Heart Disease	☐	☐	☐
Congenital Heart Disease	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Pacemaker or Artifical Heart Valve	☐	☐	☐
Any Prosthetics If Currently, when/where were they placed?__________	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Heart Murmur	☐	☐	☐
If currently, have you ever been told that you should premedicate? Y N			
Stroke	☐	☐	☐
Dizziness or Fainting	☐	☐	☐
Convulsions/Epilepsy	☐	☐	☐
Psychiatric Treatment	☐	☐	☐
Hepatitis (circle type) A B C	☐	☐	☐
Any Contagious diseases	☐	☐	☐
Venereal Disease	☐	☐	☐
AIDS or HIV+ test result	☐	☐	☐
Latex sensitivity	☐	☐	☐
Allergies to any metals or minerals?	☐	☐	☐

Is there any disease or condition not listed above that you have been diagnosed with? Y N
If yes, please explain: ____
Have you had joint replacement within the last two years? Y N
If yes, what type and when? ____________________________
Are you pregnant or think you may be pregnant? Y N
If yes, what is your due date? ___________________________
Are you nursing? Y N
Are you taking any medications? (This includes prescription, over-the-counter, or herbal medicines) Y N
Please list all medications including dosage and frequency: ____
____
____
Are you taking any medications for the treatment of osteoporosis,bone pain or bone disease? Y N
____
Any allergies or adverse reactions to: (please circle) Penicillin Aspirin Sulfa Drugs Latex
Local Anesthetic Other (Please list below)
____
Are you under a physician's care now? Y N
Please list any surgeries you have had: ____
Have you been hospitalized for any reason within the past five years? Y N
If yes, please explain: ____

Over Please

Oral Hygiene History

Last Dental Visit______________________________________
Were radiographs (xrays) taken at that visit? Y N
When was your last full mouth set of radiographs (xrays) taken?____________________

Do you have or have you ever had any of the following: (Please mark the appropriate column)

	Currently	In the Past	Never Had
Bleeding or Sore Gums	☐	☐	☐
Unpleasant taste in mouth or bad breath	☐	☐	☐
Burning tongue or lips	☐	☐	☐
Frequent blisters on lips or mouth	☐	☐	☐
Swelling or lumps in mouth	☐	☐	☐
Orthodontic treatment (braces)	☐	☐	☐
Biting cheeks or gums	☐	☐	☐
Clicking or popping jaws	☐	☐	☐
Use of tobacco products	☐	☐	☐
Loose teeth	☐	☐	☐
Sensitivity to hot	☐	☐	☐
Sensitivity to cold	☐	☐	☐
Sensitivity to sweets	☐	☐	☐
Pain while biting or chewing	☐	☐	☐
Food caught between teeth	☐	☐	☐
Clenching or grinding	☐	☐	☐
Shifting of teeth	☐	☐	☐
Changes in bite	☐	☐	☐
Cold sores, blisters or oral lesions	☐	☐	☐
Snore or have any other sleep disorders	☐	☐	☐

Are you satisfied with your teeth's appearance? YES NO
Would you like to keep all of your teeth all of your life? YES NO
Do you feel nervous about having dental treatment? YES NO
If so, what is your biggest concern?____
Have you ever had an upsetting dental experience? YES NO
If so, please describe ____

Have you had any wisdom teeth removed?(please circle) Y N Don't Know

How often do you use the following:	1x/day	2x/day	3x/day
Toothbrush………………………………….	☐	☐	☐
Dental Floss……………………………….	☐	☐	☐
Flouride rinse………………………………	☐	☐	☐
Other……………………………………….	☐	☐	☐

Toothbrush is: (please circle) Soft Medium Hard
Have you ever been told that you have gum disease (gingivitis or periodontitis)? Y N
If so, in what area? ____
Any specific areas or teeth you would like us to evaluate? Y N
If so, where?____

To the best of my knowledge, all of the preceding answers on both sides of this form are true and correct. If I ever have a change in my health or medications, I will inform the dentist at the next appointment.

Signature of Patient, Parent or Guardian:

____ Date: ________________________

WILLIAM V. DOUGHERTY III, D.D.S.

Notice of Patient Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED. IT ALSO DESCRIBES HOW YOU CAN ACCESS THIS INFORMATION.

Who Does this Notice Apply To?

Our practice applies this notice to all employees and business contractors of Drs. Dougherty and Tran. Simply put, this means anyone who can come into contact with your health information through our office.

Why Do We Publish This Notice?

As dental professionals, we understand that your health information is personal and private. We are required by law to maintain the privacy of information we gather and use about our patients. We are also required to notify you of our legal obligation to maintain your records with the utmost security.

In the course of providing dental treatment, it is sometimes necessary to share information with other parties. These parties may include dental laboratories, your insurance company or any company that the insurance company utilizes to determine benefits on your behalf.

When Is This Notice Effective?

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 11, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health

We use and disclose health information about you and your family for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your family's health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your family's health information to obtain payment for services we provide to your family.
Healthcare Operations: We may use and disclose your family's health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Uses and Disclosures of Health (cont'd)

Your Authorization: In addition to our use of your family's health information for treatment, payment or healthcare operations, you may give us written authorization to use your family's health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your family's health information to you. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, radiographs (x-rays), or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Procedures: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters). Our office utilizes a sign-in sheet that we ask you to fill in upon your arrival. If you do not wish your name to appear on the sign-in sheet please let our receptionist know.

Patient Rights

Access: You have the right to review and to obtain copies of your family's health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge

Patient Rights (cont'd)

you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a base fee of $10 and $0.50 for each page, for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your family's health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your family's health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your family's health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your family's health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your family's privacy rights, or you disagree with a decision we made about access to this health information or in response to a request you made to amend or restrict the use or disclosure of your family's health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Teresa Duncan
Telephone: 703-532-3300   Fax: 703-532-3302
E-mail: billing@doughertydds.com
Address: 200 Little Falls Street, Suite 506, Falls Church, VA 22046

William V. Dougherty III, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

____
Please Print Name

____
Signature

____
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)

____

____

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Oral Cancer Fact Sheet

Consider the facts:

- Each year approximately 30,000 people are diagnosed with cancer of the oral cavity and pharynx.
- The average years of life lost for oral cancer is 16 years, one year more than for all cancers in general.
- More deaths occur annually from oral cancers than from cervical cancer.
- Only half of those diagnosed with oral cancers are still alive after five years.
- The incidence of oral cancer and the mortality rate due to oral cancers has been almost three times greater in males than in females. African Americans have a slightly higher incidence than Caucasians.
- Between 75-90% of oral cancers are attributed to the use of tobacco of all forms.
- Alcohol use also has been positively correlated with the incidence of oral cancers.
- The relative risk for oral cancer created by combined tobacco and alcohol use is substantially greater than that for either smoking or alcohol use alone.
- More than 75% of all oral cancers can be diagnosed by sight or palpation.
- Tongue lesions account for approximately one-third of all oral cancers.
- Oral cancer is considered among the most preventable of cancers.

Early Warning Signs:

- A sore in the mouth that will not heal
- A lump or thickening in the cheek
- Difficulty chewing or swallowing
- Numbness of the tongue or other areas of the mouth
- A white or red patch on the tongue, gums or other oral tissues
- Soreness of feeling that something is caught in the throat
- Difficulty moving the tongue or jaw
- Jaw swelling that causes dentures to fit poorly