Central Virginia Dental Care, PLC
DBA
Drs. Rossetti, Myers, & Kondorossy

Patient Information

Name:_____ Birthdate:_____

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

Cell phone:_____ Preferred phone:_____ Email:_____

Sex: ❑ M ❑ F Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employer or School:_____ Phone:_____

Social Security #:_____

Person to contact in case of an emergency:_____ Phone:_____

How did you learn about our practice or whom may we thank for referring you? _____

_____

Who is responsible for your account and payment? (If different from previous listing):_____

_____

Address:_____City:_____State:_____Zip: _____

Phone:_____ Email:_____ Birthdate: _____

Dental Insurance

Insurance company:_____ Phone #: _____

Subscriber's Social Security #:_____Group #:_____ID #: _____

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

Secondary Dental Insurance

Insurance company:_____ Phone #: _____

Subscriber's Social Security #:_____Group #:_____ID #: _____

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

Dental History

Reason for today's visit:_____

Date of last dental care visit:_____ Date of last dental x-rays: _____

Former dentist's name:_____ Phone #: _____

Check if you have any problem with the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between certain teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to any of the following: cold, hot, sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

How often do you floss?_____How often do you brush?_____

Medical History

Your physician:_____ Date of last visit:_____

Have you had any serious illnesses or operations? ❑ Yes ❑ No

If yes, describe:_____

If yes, give approximate dates:_____

Women are you pregnant? ❑ Yes ❑ No

Check if you have or have had any of the following:

❑ Anemia
❑ Anxiety
❑ Arthritis, rheumatism
❑ Artificial heart valves
❑ Artificial joints, pins, ect.
❑ Asthma
❑ Bisphosphonates (osteoporosis drugs)
❑ Bleeding abnormally
❑ Blood disease
❑ Cancer
❑ Chemical dependency
❑ Chemotherapy
❑ Circulatory problems
❑ Congenital heart lesions
❑ Diabetes
❑ Epilepsy
❑ Heart problems
❑ Hemophilia
❑ Hepatitis
❑ Herpes
❑ High blood pressure
❑ HIV AIDS
❑ Jaw pain
❑ Joint replacement
❑ Kidney disease
❑ Liver disease
❑ Low bleed pressure
❑ Malignancies
❑ Mitral valve prolapse
❑ Pacemaker
❑ Radiation treatment
❑ Respiratory disease
❑ Rheumatic fever
❑ Scarlet fever
❑ Sinus issues
❑ Stroke
❑ Thyroid problems
❑ Tobacco use
❑ Tonsillitis
❑ Tuberculosis
❑ Ulcer

List medications you are currently taking and the correlating diagnosis:

Medication	Diagnosis

Please list any allergies you may have:

Allergy	Allergy

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

_____ _____

Patient or Guardian Signature *Date*

MICHAEL A. ROSSETTI, DDS, MAGD
CLAIRE MYERS, DDS
CHRISTOPHER KONDOROSSY, DDS
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Assignment of Benefits and Payment Agreement and Authorization to Release Information

I hereby authorize Central Virginia Dental Care PLC, to furnish to my insurance carrier(s), attorney, or legal representative all information which said parties may request concerning my treatment. I hereby assign to Central Virginia Dental Care PLC, until the amounts owed including interest and attorney fees are paid in full. I further agree and accept as follows:

That my insurance policy is a contract between my insurance carrier and me. I recognize that I am personally responsible to Central Virginia Dental Care PLC for ALL charges for services rendered plus interest that will acccrue on the outstanding balance at the rate of 1½% per month (18% annum).

I recognize that Central Virginia Dental Care PLC will bill and collect from my insurance carrier as a courtesy to me. I will be informed as to any balance due from me to Central Virginia Dental Care PLC I fully understand that Central Virginia Dental Care PLC may not accept the amount as the insurance carrier states as their "usual & customary fees" (UCR) as payment in full. This may lead to a bill for deductibles, co-payments, and co-insurance. Regardless of my insurance, I may have a balance due for services rendered. I agree to pay for any such balance. For those policies that require pre-authorization or referrals, this must be completed prior to seeing any dentist. I am responsible for understanding my individual insurance policy and benefits prior to seeking services. I will ask for help if my insurance is not clear to me.

Although I may be represented by an attorney on matters related to the treatment which Central Virginia Dental Care PLC has rendered to me, I must still keep my account paid in full.

If my account becomes delinquent and is referred to an attorney or agency for collection, I agree to pay a minimum of 30% attorney fees, all court costs incurred by Central Virginia Dental Care PLC in addition to the outstanding balance of the account.

I fully understand that while Central Virginia Dental Care PLC is willing to send an insurance claim to my insurance carrier, this is done as a courtesty, and Central Virginia Dental Care PLC will not be responsible for lost claims or claims that do not arrive at my insurance carrier. Patients are encouraged to remain in touch with their insurance carrier to determine the status of the claim. I understand that if payment from my insurance carrier is not received by Central Virginia Dental Care PLC within 75 days from the date of service, the TOTAL balance will become my responsibility and will be due immediately. All accounts that are 90 days old will be sent to collections.

This agreement is in addition to any other agreement which I may have with Central Virginia Dental Care PLC I have read this document, understand it fully, and agree to the terms and conditions.

Signature _____ Date _____

OUR FINANCIAL POLICY

Thank you for choosing Central Virginia Dental Care PLC as your dental care provider. The following is a statement of our Financial Policy which we ask you to read and sign prior to any treatment. All patients must complete this information before seeing the dentist.

PAYMENT IN FULL IS EXPECTED AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS and CREDIT CARDS (VISA & MASTERCARD).

Insurance

We may accept assignment of insurance benefits. The balance is your responsiblity whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original insurance card at each visit to copy and keep on file. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all of the services provided may not be covered. You will be responsible for these balances. (Initial _____)

Adult and Minor Patients

Adult patients are responsible for full payment at time of service. The adult accompanying a minor and/or the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard (which may be kept on file), or payment by cash or check at time of service has been verified. (Initial _____)

Returned Checks

There will be a $30 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, we will call your bank to verify funds for any future checks that are presented for payment on your account. (Initial_____)

Collection Fees

In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees. (Initial_____)

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for a missed appointment at the rate of no less than $100 per missed appointment. Please help us to serve you better by keeping scheduled appointments. (Initial_____)

Fees for Letters and Forms

Your Dentist will be more than happy to fill out any necessary forms that you may need. Please be advised that due to the time required to dictate and complete letters and forms there will be a fee for this service. These costs are considered non-covered by the insurace companies. The fee for this service is $20.00. (Initial_____)

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.
I have read the Financial Policy. I understand and agree to this Financial Policy:

x _____ Date _____
Signature of Patient or Responsible Party

x _____ Date _____
Signature of Co-Responsible Party

Central Virginia Dental Care PLC
dba
Michael A Rossetti DDS, Claire Myers DDS, Christopher Kondorossy DDS

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)

_____

_____

_____