BROADVIEW DENTAL

571-584-0020
hello@broadviewdentalva.com
101 W Broad Street Suite 200
Falls Church, VA 22046

New Patient Registration Form

Patient Information:

Patient Name:_____ Preferred Name:_____
If Child, Parent/Guardian Name(s): _____
Date of Birth:_____ Social Security Number:_____
Gender: ☐ Male ☐ Female ☐ Other Marital Status: ☐ Single ☐ Married ☐ Divorced
Address:_____ City:_____ State:_____ Zip:_____
Cell Phone:_____ Home Phone:_____ Work Phone:_____
Email Address:_____ ☐ Yes, it is okay to send me text and email reminders
Preferred Method of Contact: ☐ Cell ☐ Home ☐ Work ☐ Email
Emergency Contact:_____ Phone:_____
Relationship to the Patient:_____
Pharmacy Name:_____ Phone Number:_____
Address:_____
How did you hear about us?: ☐ Google ☐ Friend/Family ☐ Insurance ☐ Social Media
☐ Other:_____

Insurance Information:

Primary Insurance Company:_____
Subscriber Name:_____ Subscriber Date of Birth:_____
Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____
Member ID:_____

Secondary Insurance Company:_____
Subscriber Name:_____ Subscriber Date of Birth:_____
Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____
Member ID:_____

Do you currently have a primary medical plan with dental benefits? If yes, please provide the information below.

Medical Insurance Company:_____
Subscriber Name:_____ Subscriber Date of Birth:_____
Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____
Member ID:_____

Medical History:

Have you had any major surgeries? ☐ Yes ☐ No
If yes, what and when?_____
Do you have any allergies? ☐ Yes ☐ No
If yes, please list: _____
Have you ever had a reaction to dental or local anesthesia? ☐ Yes ☐ No
If yes, describe the reaction:_____
Do you require antibiotics prior to appointments? ☐ Yes ☐ No
If yes, why?_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No
If yes, why and when?_____
Do you have a pacemaker or implanted defibrillator? ☐ Yes ☐ No
If female, are you pregnant or nursing? ☐ Yes ☐ No
If yes, please provide your physicians information below:
Physician Name:_____ Physician Number:_____
Estimate Due Date:_____
Do you smoke or use tobacco products? ☐ Yes ☐ No If yes, how often?_____
Do you drink alcohol? ☐ Yes ☐ No If yes, how much?_____

Please list all medications that you take regularly, including supplements, over the counter medications, vitamins, and herbal supplements: _____
_____
_____
_____

Do you currently have, or have you ever been diagnosed with any of the following medical conditions?
Please circle all that apply:

☐ Anemia
☐ Arthritis
☐ Artificial Bones/Joints
☐ Artificial Valves
☐ Asthma
☐ Autoimmune Disorder
☐ Back Problems
☐ Blood Clotting Disorder
☐ Blood Thinners
☐ Blood Transfusions
☐ Cancer
☐ COPD
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Difficulty Breathing
☐ Drug or Alcohol Dependency
☐ Eating Disorder
☐ Emphysema
☐ Epilepsy
☐ Fainting
☐ Frequent Headaches
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ HIV/AIDS
☐ Kidney Disease
☐ Kidney Problems
☐ Low Blood Pressure
☐ Migranes
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pace Maker
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Seasonal Allergies
☐ Seizures
☐ Shingles
☐ Sinus Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Venereal Disease
☐ Other:_____

Dental History:

When was your last dental visit?_____

When was your last dental cleaning?_____

Have you had dental x-rays taken in the last 12 months? ☐ Yes ☐ No

How often do you brush your teeth?

☐ Less than once a day ☐ Once daily ☐ Twice daily ☐ More than twice a day

How often do you floss?

☐ Rarely/Never ☐ Occasionally ☐ Several times per week ☐ Daily ☐ Twice a day

Does going to the dentist make you anxious? ☐ Yes ☐ No

Have you ever had a bad dental experience? ☐ Yes ☐ No

If yes, please describe:_____

Please circle any of the following that apply to you:

☐ Bleeding Gums

☐ Sensitive Teeth

☐ Gum Disease / Periodontal Disease

☐ Loose Teeth

☐ Bad Breath

☐ Dry Mouth

☐ Food Frequently Gets Stuck Between Teeth

☐ Tooth Pain

☐ Jaw Pain / TMJ Problems

☐ Clicking or Popping of the Jaw

☐ Clenching or Grinding Teeth

☐ Frequent Headaches

☐ Dental Anxiety

☐ History of Dental Trauma

☐ Broken Teeth

☐ Missing Teeth

☐ Crowns

☐ Bridges

☐ Dental Implants

☐ Dentures

Are there any concerns about your teeth, gums, mouth, or smile that you would like to discuss with the dentist? ☐ Yes ☐ No

If yes, please describe:_____

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Patient Financial and Office Policies

Please review the following policies carefully. By signing below, you acknowledge that you have read, understand, and agree to these policies.

Payment Policy

Payment is due at the time services are rendered unless other arrangements have been made in advance.

As a courtesy, Broadview Dental may verify insurance benefits, submit claims, and assist with claim processing; however, insurance coverage and payment are determined solely by your insurance carrier. Verification of benefits is not a guarantee of payment.

Patients are responsible for all charges incurred, regardless of insurance coverage. Any balance not paid by insurance remains the responsibility of the patient or responsible party. Broadview Dental reserves the right to collect estimated patient portions at the time of service and require payment arrangements before scheduling certain procedures.

Returned checks, chargebacks, and unpaid balances may be subject to additional fees and collection activities as permitted by law.

Cancellation and Missed Appointment Policy

If you need to cancel or reschedule an appointment, please provide at least twenty-four hours' notice.

Appointments missed without notice or cancelled with less than twenty-four hours' notice may be subject to a $50 missed appointment or late cancellation fee.

Patients who miss appointments or provide insufficient notice on three occasions may be subject to dismissal from the practice. Broadview Dental also reserves the right to require deposits, limit scheduling options, or place patients on same-day scheduling status due to repeated missed appointments or late cancellations.

Patient Conduct Policy

To maintain a safe and respectful environment, Broadview Dental reserves the right to refuse treatment, reschedule appointments, or dismiss patients for disruptive, threatening, abusive, harassing, discriminatory, or inappropriate behavior toward staff, providers, or other patients.

Examples include verbal abuse, threats, intimidation, harassment, property damage, inappropriate conduct, or repeated refusal to follow office policies. Emergency treatment will not be withheld when required by law.

Audio, Video Recording, and Privacy Policy

To protect the privacy of patients, visitors, and staff, audio recording, video recording, photography, live streaming, or other forms of recording are not permitted within the office without prior authorization from Broadview Dental.

Unauthorized recording may result in suspension of treatment, termination of the appointment, removal from the premises, or dismissal from the practice.

Medical and Dental Records Requests

Patients may request copies of their medical and dental records by submitting a written request to Broadview Dental. We ask that patients allow at least 48 business hours from the time the request is received for records to be processed and released.

Records will be provided electronically unless an alternative format is specifically requested. Reasonable fees permitted by law may apply for paper copies, mailing costs, or other administrative expenses associated with fulfilling the request.

Communication Policy

By providing your contact information, you authorize Broadview Dental to contact you regarding appointments, treatment recommendations, recall visits, billing matters, insurance issues, and other healthcare-related communications.

Unless you notify us otherwise, communications may be sent by telephone, voicemail, text message, email, mail, or other contact methods you provide.

Acknowledgment

I acknowledge that I have received, read, understand, and agree to Broadview Dental's Patient Financial and Office Policies.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received or have been offered the opportunity to receive a copy of Broadview Dental's Notice of Privacy Practices. The Notice of Privacy Practices explains how my protected health information may be used and disclosed and describes my rights regarding that information.

I understand that Broadview Dental reserves the right to change its Notice of Privacy Practices and that a current copy will be available upon request and in the office.

Authorization to Discuss Health Information

I authorize Broadview Dental to discuss my appointment information, treatment recommendations, insurance benefits, billing information, and other healthcare-related matters with the following individual(s):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ I do not authorize Broadview Dental to discuss my protected health information with any other individual.

I understand that I may revoke or modify this authorization at any time by providing written notice to Broadview Dental.

Patient Name: _____

Signature of Patient_____ Date: _____

If signed by a personal representative, please indicate relationship to patient:

Office Use Only

☐ Patient declined acknowledgment of Notice of Privacy Practices

Reason (if provided): _____

Staff Initials: _____ Date: _____

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CONSENT FOR EXAMINATION, DIAGNOSTIC PROCEDURES, AND TREATMENT PLANNING

As part of your dental care, the doctors and staff at Broadview Dental will evaluate the health of your teeth, gums, supporting bone, jaw joints, oral tissues, head, and neck. The purpose of this examination is to identify existing conditions, detect potential concerns, and develop appropriate treatment recommendations based on your individual needs.

As part of this evaluation, we may perform a periodontal assessment to evaluate the health of your gums and supporting structures. This may include measuring the spaces between the teeth and gums, assessing gum recession, evaluating bone support, and screening for periodontal disease or other conditions affecting oral health.

Diagnostic imaging may also be necessary to properly evaluate your oral health. Depending on your individual needs, this may include bitewing, periapical, panoramic, cephalometric, or cone beam computed tomography (CBCT) radiographs. These images help identify conditions that may not be visible during a clinical examination, including cavities, infections, bone loss, impacted teeth, fractures, cysts, tumors, and other abnormalities.

In some cases, additional diagnostic records may be recommended, including intraoral or extraoral photographs, digital scans, study models, oral cancer screenings, blood pressure readings, or other assessments necessary for diagnosis, treatment planning, documentation, communication with specialists, or monitoring changes over time.

Benefits, Risks, and Alternatives

The primary benefit of these diagnostic procedures is obtaining the information necessary to accurately evaluate your oral health and develop appropriate treatment recommendations. A complete examination and diagnostic workup allow the doctor to identify conditions that may not be visible or symptomatic and to recommend treatment based on the most accurate information available.

The risks associated with dental examinations, periodontal charting, photographs, digital scans, and diagnostic imaging are generally minimal. Although dental radiographs involve exposure to small amounts of radiation, modern digital imaging technology is designed to minimize exposure while providing valuable diagnostic information.

While patients may choose to decline recommended diagnostic procedures, doing so may limit our ability to accurately diagnose conditions, identify potential concerns, or provide comprehensive treatment recommendations.

Consequences of Refusing Recommended Diagnostic Procedures

Without a complete examination and appropriate diagnostic records, certain conditions may go undetected or may not be diagnosed until they have progressed. Delayed diagnosis may result in increased treatment complexity, additional costs, discomfort, infection, tooth loss, periodontal disease progression, or other complications.

Broadview Dental will make every reasonable effort to provide an accurate diagnosis and treatment recommendation; however, the accuracy and completeness of those recommendations may be limited when recommended diagnostic procedures are declined.

By signing below, I acknowledge that I have read and understand the information above. I have had the opportunity to ask questions regarding the recommended examination and diagnostic procedures, and all of my questions have been answered to my satisfaction.

I understand the purpose, benefits, risks, and limitations of the recommended examination and diagnostic procedures and consent to the services necessary for the evaluation of my oral health and development of an appropriate treatment plan.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____