DAVIS & NYCZEPIR
ORTHODONTICS

Specialists in Orthodontics & Dentofacial Orthopedics

Office Location You Would Prefer _____ Bon Air_____ Midlothian_____ Chester_____ Amelia Date _____

Patient Name _____ Preferred Name_____
First Middle Last
Age _____ Date of Birth _____ (F) _____ (M) _____ Home/Cell # _____
Street Address_____
City _____ State _____ Zip_____
Patient's Hobbies/Sports/Interest_____
Name & Ages of children in immediate family _____

Person financially responsible _____ Social Security# _____
Address_____
Email address _____ Best # to reach you _____
If patient is a minor:
Father/Legal Guardian Name _____ Home/Cell #_____
Address_____
Employment _____ Work Telephone_____
Employment Address_____
Social Security_____ Date of Birth_____
Email Address_____ Best # to reach you_____
Mother/Legal Guardian Name_____ Home /Cell#_____
Address_____
Employment _____ Work Telephone _____
Employment Address_____
Social Security _____ Date of Birth_____
Email Address _____ Best # to reach you_____
Child resides with _____ Both Parents _____ Mother_____ Father_____
Best Method of Contact to confirm appointments _____ Home/Cell _____ Text _____ Email
If Orthodontic Insurance, **Please Fill Out Attached Form.**
Is the patient being treated now by a Physician for any conditions? Yes_____ No_____
If yes, explain_____

Has the patient ever had any of the following? If yes, Please Check:

o Rheumatic Fever	o Diabetes	o Allergies	Medications being taken:
o Heart Disease	o TMJ	o Asthma	_____
o Blood Disorder	o Arthritis	o High Blood Pressure	_____
o Heart Murmur	o Mental Disorders	o Tonsillectomy	_____
o Seizures	o Hepatitis	o Tuberculosis (or lived with someone who had TB also)	

o Other _____
_____

Could you possibly have been exposed to either Hepatitis or Aids Virus by working with affected people or blood by-products, transfusion,direct exposure, etc? Yes ___ No __ (If yes,explain) _____

Physician's Name _____
Dentist's Name _____
Date of last dental check up _____
Previous Orthodontic treatment? ___ If yes, name of Orthodontist _____ Phone#_____
Who may we thank for referring you to our practice? _____

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCOLSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IF CAREFULLY

Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, social security number, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e. your general dentist, oral surgeon, etc.) In connection with our rendering orthodontic treatment to you (i.e. to determine the results of cleanings, surgery, ect.);
- To third party payers or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e. to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e. the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Request and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of violation).
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We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we so, we will provide you with a copy of the revised Privacy Notice.
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Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure or your protected health information;
- Amend you protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

SIGNATURE REQUIRED ON BACK OF PAGE (Please continue)

Patient Name _____ DOB _____

LIST NAMES OF PERSONS YOU GIVE PERMISSION FOR US TO SHARE YOUR INFORMATION WITH

NAME RELATIONSHIP

1. _____

2. _____

3. _____

4. _____

This privacy notice is effective as of this date of your signature. It you have any questions about the information in this Notice, Please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGEMENT

Hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____

Signature Date

DAVIS & NYCZEPIR
ORTHODONTICS

GEORGE E. DAVIS, III,D.D.S.

DAVID J. NYCZEPIR, SR., D.D.S.

Records Agreement

At this time, there is no fee for acquiring orthodontic diagnostic records. Records include photographs, x-rays, impressions for study models and a clinical exam. This procedure will be followed by a consultation, to discuss all aspects of the treatment. This will also be done at no charge.

If you request that the orthodontic records be transferred to another office, a duplicating and transferring fee of $300.00 will be due prior to the release of records.

Print Patient's Name: _____

Signature: _____

Date: _____

1009 CROWDER DRIVE
MIDLOTHIAN, VIRGINIA 23113
(804) 794-4213

9015 FOREST HILL AVENUE
RICHMOND, VIRGINIA 23235
(804) 272-7528

10436 IRONBRIDGE ROAD
CHESTER, VIRGINIA 23831
(804) 748-3234

7100 COSBY VILLAGE ROAD
CHESTERFIELD, VIRGINIA 23832
(804) 821-6770

DRS. DAVIS & NYCZEPIR, LTD

9015 Forest Hill Ave.
Richmond, VA 23235
(804) 272-7528

1009 Crowder Dr.
Midlothian, VA 231 I 3
(804) 794-4213

10436 Iron Bridge Road
Chester, VA 23831
(804) 748-3234

INSURANCE GUIDELINES

- We will gladly file your insurance claims if complete information is provided to our office.
- It is the responsibility of the insured to be informed of their insurance benefits. Our office will help to determine these benefits if assistance is requested.
- Although our office participates with only certain insurance carriers, many dental plans have in and out-of-network benefits available for orthodontics.
- If you desire a pretreatment estimate be filed with your insurance company, this must be requested. We do not submit pretreatment estimates as standard practice.
- Please be aware that, with the exception of a few, insurance companies pay the orthodontic benefit over the course of treatment. In order to receive the full benefit, the insurance needs to be in effect for the length of treatment.
- If your insurance changes or terminates please notify our office.
- If insurance terminates or does not pay the expected amount (as indicated on the Federal Truth-in - Lending statement), the patient/responsible party will be responsible for any outstanding balance.

AUTHORIZATION FOR INSURANCE FILING

I have read and accept the insurance guidelines as presented.

Signature_____ Date _____

I authorize the office of Drs. Davis & Nyczepir, Ltd to release any medical information related to treatment provided in our office to my insurance company for the purpose of processing claims.

Signature _____ Date _____

I authorize and direct payment of dental insurance benefits directly to the office of Drs.Davis & Ncyzepir, Ltd.

Signature _____ Date_____

DRS.DAVIS & NYCZEPIR LTD
DENTAL INSURANCE INFORMATION

Please complete all information: Incomplete information could delay filing/processing. Our business office can assist you with any questions or concerns that you may have.

Today's Date_____Effective Date of Policy_____

Patient's Name_____
Patient's Date of Birth_____

Policyholder's Name_____
Policyholder's Date of Birth_____Relationship to Patient_____
Policyholder's Place of Employment_____

Insurance Member ID number_____
Insurance Group Number_____

Name of Insurance Company_____
Insurance Company Address_____
Insurance Company Phone_____

Please provide a copy of your insurance card to our office.

PAYMENT OPTIONS

For your convenience, we offer the following options for making payment:

A 5% discount is offered for payment in full at the start of treatment on out-of-pocket expenses greater than $1,000.

Our office can schedule automatic withdrawal of funds from your credit/debit/FSA card. Please see business office or receptionist for authorization form. Our office accepts Visa, MasterCard and Discover cards.

Our office will automatically mail you a coupon book after the start of treatment to use in making your payments. If you plan on using automatic bill pay through your bank or setting up automatic card payments with our office and do not require a coupon book, please initial here_____.

PHOTO RELEASE

(optional)

I, _____, grant Drs. Davis & Nyczepir, LTD to take photos of my face, mouth and teeth before, during and after treatment. I authorize Drs. Davis & Nyczepir, LTD to use these photographs for the purpose of orthodontic records, marketing and patient education. I understand that my photos will be used at my Orthodontists' discretion in the office, on our website or any marketing materials. I do not expect compensation, financial or otherwise, for the use of these photographs.

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice.

Patient's Name _____

Signature _____ Date _____

☐ Check here if you do not wish for your photographs to be used for any of the above purposes