Carl G. Lebo, D.D.S., P. C. Ph. 703-525-0233

3801 N. Fairfax Dr. # 72, Arlington, VA 22203 www.carlglebo.com

Name: _____ Sex: ____ M ____F

Home Phone: _____Work Phone: _____ Cell Phone: _____

Social Security #: _____ Date of Birth: _____

Email Address: _____ Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Driver's License Number: _____ State: _____ Exp. Date: _____

Employer Information

Employer Name: _____ Phone: _____

Employer Address: _____

Spouse's Name: _____ Work Phone: _____

Nearest relative not living with you: _____ Phone: _____

Primary Care or Referring Physician: _____ Phone: _____

Whom may we contact in the case of an emergency? _____Phone: _____

Whom may we thank for referring you to us? _____ Phone: _____

Who is responsible for this bill? _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____

Name of employer: _____ Office Phone: _____

Insurance Company: _____ Group #:_____ Employer/ID# _____

Insurance company address: _____ City/State: _____ Zip: _____

Do you have Secondary Insurance? ___Yes ___No

Name of Insured: _____Relationship to Patient: _____

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Birthdate: _____ Social Security Number: _____

Name of employer: _____ Office Phone: _____

Insurance Company: _____ Group #: _____ Employer/ID# _____

Insurance company address: _____ City/State: _____ Zip: _____

Medical History: Do you have or had any of the following (Please circle)

AIDS	Anemia	Arthritis/Rheumatism	Artificial Heart Valves
Artificial Joints	Back Problems	Bleeding Abnormalities	Blood Disease
Cancer	Chemical Dependency	Chemotherapy	Circulatory problem
Congenital Heart Lesions	Cortisone Treatments	Diabetes	Epilepsy
Fainting	Glaucoma	Headaches	Heart Murmur
Heart Attack	Heart Problems	Hemophilia	Hepatitis
High Blood Pressure	HIV Positive	Kidney Disease	Liver Disease
Mitral Valve Prolapse	Pacemaker	Psychiatric Care/ Problems	Radiation Treatment
Respiratory Disease	Rheumatic Fever	Shortness of Breath	Skin Rash
Sinus Problems	Stroke	Thyroid Problems	Tobacco Habit
Tuberculosis			

Are there any other health conditions you have that are not listed? If so, please explain:

_____

Please List all Allergies:

_____

Please List all Medications You are Taking:

_____

Women Only:

Are you Pregnant? __ Yes __ No Nursing? __ Yes __No Had an exposure to HPV? __ Yes __No

Date of Last Dental Exam: _____ Reason for Today's Visit: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I

will notify you of any changes in my status or in the above information. **This information will be kept confidential.**

_____ _____

Signature Date

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment at *Carl G. Lebo, D.D.S., P. C.* is to serve our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information. During the course of serving your interests, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of a billing service.
- During healthcare operations, we may need a second opinion.

(Include any other examples of situations where Protected Health Information may be shared.)

We at *Carl G. Lebo, D.D.S., P. C.* are committed to obeying all Federal, State and local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

I have read and understand the above Notice of Privacy Practices.

Signed_____ Date_____