GENE C. MEARS D.D.S.

Medical Arts Building, Suite 104
2301 Fall Hill Ave., Fredericksburg, VA 22401
Phone: 540/373-7901 | Fax: 540/310-4849

Office of Dr. Gene C. Mears
# PATIENT INFORMATION

First Name:_____ Last Name:_____ MI:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Birth Date:_____ Soc. Sec.#:_____ Drivers Lic.#:_____

Email:_____

*Responsible Party information if patient is a minor or has a guardian*

First Name:_____ Last Name:_____ MI:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Birth Date:_____ Soc. Sec.#:_____ Drivers Lic.#:_____

---

**How did you hear about our office?** [ ] Patient Referral [ ] Phonebook [ ] Internet [ ] Other

**We are dedicated to your treatment and take pride in the quality of care that we deliver. In order to avoid misunderstandings, we provide the following information:**

As a courtesy to you, we will file most insurance claims. However, your insurance coverage is an agreement between you and your insurance company. We do not necessarily accept insurance company allowances as full payment for your account. Due to the volume of claims filed by our office, we are unable to follow up on unpaid or unprocessed claims.

After **60 days**, any unpaid insurance claims become your full responsibility. Since insurance policies vary greatly, it is **your** responsibility to contact your insurance company if you have any questions regarding your policy, claim and to make sure your claims have been paid.

**Payment is required at the time of service**. We accept cash, personal checks, Visa, MasterCard or Care Credit. A **$25 fee** will be collected for all checks returned by the bank. **A handling fee of 1.5% or $5** (whichever is greater) will be applied to balances that require billing. This charge will be applied each month until account has been paid in full. The undersigned agrees to pay a fee for any missed appointments or appointments cancelled when less than one working days notice is given for a fee of **$45 per 30 minutes** of scheduled time. Insurance companies **will not** pay missed appointment fees.

In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay **18% interest** per year on all balances which are unpaid **60 days** after the services are rendered. All accounts due over **90 days** will be sent to Collections. The patient or his/her legal guardian is responsible for all charges made for treatment rendered by Dr. Mears and Staff. If a collection agency, lawyer or other party is used to assist in collection of the account, any and all charges and fees made by these people, agencies or courts will be added to the patient's account.

In absence or prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney or collection agency for collection. These companies will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I [ ] **am** [ ] **am not** an active duty member of the U.S. Armed Forces.

_____ _____

Date Responsible Party Signature

GENE C. MEARS D.D.S.

Medical Arts Building, Suite 104
2301 Fall Hill Ave., Fredericksburg, VA 22401
Phone: 540/373-7901 | Fax: 540/310-4849

Office of Dr. Gene C. Mears

# USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that the office of Dr. Gene C. Mears may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered or have received in the past, a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice and individuals involved in my care in the Practice may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at 540/373-7901.

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice or individuals involved in my care in the Practice have already used or disclosed my protected health information in reliance on my prior consent.

| _____ | _____ | _____ |
|---|---|---|
| Date | Patient or Legal Surrogate | Please Print Name |

GENE C. MEARS D.D.S.

Medical Arts Building, Suite 104
2301 Fall Hill Ave., Fredericksburg, VA 22401
Phone: 540/373-7901 | Fax: 540/310-4849

Office of Dr. Gene C. Mears

# RELEASE OF INFORMATION

**I hereby authorize the following:**

1. Any information regarding my treatment to myself and anyone listed below (spouse, parents, etc.)
   _____
2. Assignment of insurance payment to Dr. Gene C. Mears
3. The release of any and all medical information to other treating dentists and insurance carrier for the purpose of claims administration.
4. The release of any testing results from another treating dentist or facility in which testing was performed to Dr. Gene Mears
5. If applicable, I also authorize release of information to my attorney (with a signed order)

_____ _____

Date Responsible Party Signature

**Insurance Information**

Please select one of the following:

[ ] I do not have dental insurance [ ] I do have dental insurance (*please complete the following*)

**Primary Insurance Information – must be completed in full**

Policy Holder:_____ Group #:_____

Policy Holder ID#:_____

Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other

Policy Holder Soc. Sec.#:_____ Policy Holder Date of Birth:_____

Employer:_____ Address:_____

City:_____ State:_____ Zip:_____

Insurance Co:_____ Address:_____

City:_____ State:_____ Zip:_____

**Secondary Insurance Information**

Policy Holder:_____ Group #:_____

Policy Holder ID#:_____

Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other

Policy Holder Soc. Sec.#:_____ Policy Holder Date of Birth:_____

Employer:_____ Address:_____

City:_____ State:_____ Zip:_____

Insurance Co:_____ Address:_____

City:_____ State:_____ Zip:_____

**I acknowledge payment is due at time of treatment and I accept full responsibility for all charges. Furthermore, I acknowledge to inform this office as to my complete insurance coverage, noting any changes that have occurred at the time services are rendered. Failure to completely disclose all aspects of my insurance will deem me financially responsible for all charges from date of service. I understand that after 60 days, all pending insurance claims will become my responsibility.**

_____ _____ _____

**Date** **Patient/Guardian Signature** **Please Print Name**

GENE C. MEARS D.D.S.

Medical Arts Building, Suite 104
2301 Fall Hill Ave., Fredericksburg, VA 22401
Phone: 540/373-7901 | Fax: 540/310-4849

Office of Dr. Gene C. Mears

# CONSENT FOR TREATMENT

1. I hereby authorize Dr. Gene C. Mears and Staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize Dr. Gene Mears to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name | Patient or Responsible Party Signature | Date |

GENE C. MEARS D.D.S.

Medical Arts Building, Suite 104
2301 Fall Hill Ave., Fredericksburg, VA 22401
Phone: 540/373-7901 | Fax: 540/310-4849

Office of Dr. Gene C. Mears

# MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? [ ] Yes [ ] No If yes, please explain:_____
Have you ever been hospitalized/had a major operation? [ ] Yes [ ] No If yes, please explain:_____
Have you ever had a serious head or neck injury? [ ] Yes [ ] No If yes, please explain:_____
Are you taking any medications, pills or drugs? [ ] Yes [ ] No If yes, please explain:_____
Do you take, or have you taken Phen-Fen or Redux? [ ] Yes [ ] No
Are you on a special diet? [ ] Yes [ ] No
Do you use tobacco? [ ] Yes [ ] No
Do you use controlled substances? [ ] Yes [ ] No

**Women: Are you**

Pregnant/trying to get pregnant? [ ] Yes [ ] No Taking oral contraceptives? [ ] Yes [ ] No Nursing? [ ] Yes [ ] No

**Are you allergic to any of the following:**

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Local Anesthitics
[ ] Other If yes, please explain:_____

Please mark yes or no to every question:

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV Positive | [ ] Yes [ ] No | Excessive Bleeding | [ ] Yes [ ] No | Lung Disease | [ ] Yes [ ] No |
| Alzheimer's Disease | [ ] Yes [ ] No | Excessive Thirst | [ ] Yes [ ] No | Mitral Valve Prolapse | [ ] Yes [ ] No |
| Anaphylaxis | [ ] Yes [ ] No | Fainting Spells/Dizziness | [ ] Yes [ ] No | Pain in Jaw Joints | [ ] Yes [ ] No |
| Anemia | [ ] Yes [ ] No | Frequent Cough | [ ] Yes [ ] No | Parathyroid Disease | [ ] Yes [ ] No |
| Angina | [ ] Yes [ ] No | Frequent Diarrhea | [ ] Yes [ ] No | Psychiatric Care | [ ] Yes [ ] No |
| Arthritis/Gout | [ ] Yes [ ] No | Frequent Headaches | [ ] Yes [ ] No | Radiation Treatments | [ ] Yes [ ] No |
| Artificial Heart Valve | [ ] Yes [ ] No | Genital Herpes | [ ] Yes [ ] No | Recent Weight Loss | [ ] Yes [ ] No |
| Artificial Joint | [ ] Yes [ ] No | Glaucoma | [ ] Yes [ ] No | Renal Dialysis | [ ] Yes [ ] No |
| Asthma | [ ] Yes [ ] No | Hay Fever | [ ] Yes [ ] No | Rheumatic Fever | [ ] Yes [ ] No |
| Blood Disease | [ ] Yes [ ] No | Heart Attack/Failure | [ ] Yes [ ] No | Rheumatism | [ ] Yes [ ] No |
| Blood Transfusion | [ ] Yes [ ] No | Heart Murmur | [ ] Yes [ ] No | Scarlet Fever | [ ] Yes [ ] No |
| Breathing Problem | [ ] Yes [ ] No | Heart Pace Maker | [ ] Yes [ ] No | Shingles | [ ] Yes [ ] No |
| Bruise Easily | [ ] Yes [ ] No | Heart Trouble/Disease | [ ] Yes [ ] No | Sickle Cell Disease | [ ] Yes [ ] No |
| Cancer | [ ] Yes [ ] No | Hemophilia | [ ] Yes [ ] No | Sinus Trouble | [ ] Yes [ ] No |
| Chemotherapy | [ ] Yes [ ] No | Hepatitis A | [ ] Yes [ ] No | Spina Bifida | [ ] Yes [ ] No |
| Chest Pains | [ ] Yes [ ] No | Hepatitis B or C | [ ] Yes [ ] No | Stomach/Intestinal Disease | [ ] Yes [ ] No |
| Cold Sores/Fever Blisters | [ ] Yes [ ] No | Herpes | [ ] Yes [ ] No | Stroke | [ ] Yes [ ] No |
| Congenital Heart Disorder | [ ] Yes [ ] No | High Blood Pressure | [ ] Yes [ ] No | Swelling of Limbs | [ ] Yes [ ] No |
| Convulsions | [ ] Yes [ ] No | Hives or Rash | [ ] Yes [ ] No | Thyroid Disease | [ ] Yes [ ] No |
| Cortisone Medicine | [ ] Yes [ ] No | Hypoglycemia | [ ] Yes [ ] No | Tonsillitis | [ ] Yes [ ] No |
| Diabetes | [ ] Yes [ ] No | Irregular Heart Beat | [ ] Yes [ ] No | Tuberculosis | [ ] Yes [ ] No |
| Drug Addiction | [ ] Yes [ ] No | Kidney Problems | [ ] Yes [ ] No | Tumors or Growths | [ ] Yes [ ] No |
| Easily Winded | [ ] Yes [ ] No | Leukemia | [ ] Yes [ ] No | Ulcers | [ ] Yes [ ] No |
| Emphysema | [ ] Yes [ ] No | Liver Disease | [ ] Yes [ ] No | Venereal Disease | [ ] Yes [ ] No |
| Epilepsy or Seizures | [ ] Yes [ ] No | Low Blood Pressure | [ ] Yes [ ] No | Yellow Jaundice | [ ] Yes [ ] No |

Have you ever had any serious illness not listed above? [ ] Yes [ ] No If yes, please explain:_____

Comments:_____
_____

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

_____ _____
Date Signature of Patient, Parent or Guardian

GENE C. MEARS D.D.S.

Medical Arts Building, Suite 104
2301 Fall Hill Ave., Fredericksburg, VA 22401
Phone: 540/373-7901 | Fax: 540/310-4849

Office of Dr. Gene C. Mears

# PATIENT QUESTIONNAIRE

1. What is the reason for today's visit?

_____

_____

_____

2. If you could wave a magic wand and change one thing about your smile what would it be? -

_____

_____

3. If there were a simple, inexpensive way to **whiten** your teeth, would you be interested? Please circle: Yes No

4. Why did you **leave** your last dentist?

_____

_____

_____

5. What did you **like most** about any dental office you have ever been seen in?

_____

_____

_____

6. What did you **like least** about any dental office you have ever been seen in?

_____

_____

_____

7. On a scale of 1 to 10 how would you **rate your smile**?

1 2 3 4 5 6 7 8 9 10

8. What would **you change** to make your smile a 10?

_____

_____

_____