



a wink & a smile

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred / Nickname: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: _____ Social Security: _____
Address: _____ Address 2: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Ext: _____ Cellular: _____
E-mail: _____
Employer: _____ Full time Part Time Retired Student

Policy Holder / Parent / Guardian (If different from patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Birth Date: _____ Social Security: _____ Drivers Lic: _____
 Mark if address is same as above
Address: _____ Address 2: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Ext: _____ Cellular: _____
E-mail: _____ Employment Status: Full time Part Time Retired

Insurance Information

Primary Insurance (Please provide card if available) – Please supply as much information as possible.

Name of Insured: _____ Insured is: Patient Spouse Parent Other
*Insured ID #: _____ Insured Birth Date: _____
Employer: _____ Insur. Company: _____
Group Number: _____ Address: _____
Phone Number: _____ City,State,Zip: _____

*Required (social security or member ID)

Secondary Insurance (If applicable - please provide card if available)

Name of Insured: _____ Insured is: Patient Spouse Parent Other
Insured ID #: _____ Insured Birth Date: _____
Employer: _____ Insur. Company: _____
Group Number: _____ Address: _____
Phone Number: _____ City,State,Zip: _____

Referred by: Mailer Insurance Patient: _____ Other: _____
Previous Doctor: _____ City,State: _____ Phone: _____
Emergency Contact: _____ Phone: _____ Relationship: _____



Patient Name: _____

Date of Birth: _____

Date: _____

MEDICAL HISTORY

Are you under a physician's care now? No Yes If yes: _____

Have you ever been hospitalized or had a major operation? No Yes If yes: _____

Have you ever had a serious head or neck injury? No Yes If yes: _____

Are you taking any medications, pills, or drugs? No Yes If yes: _____

Do you take or have you taken Phen-Fen or Redux? No Yes If yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? No Yes If yes: _____

Are you on a special diet? No Yes If yes: _____

Do you use tobacco? No Yes If yes: _____

WOMEN: Are you... Pregnant Trying to get pregnant Nursing Taking oral contraceptives

Are you allergic to any of the following?

Aspirin Penicillin Codeine Drugs Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Other? Yes: _____ Do you use controlled substances? No Yes If yes: _____

Do you have or have you had any of the following:

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

Have you ever had any serious illness not listed above? Yes No 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 office of ANY changes in medical status.

Signature of Patient, Parent, or Guardian:

X _____

Date: _____



Financial Policy & Receipt of Privacy Practices

It is our policy at a wink & a smile to provide all of our patients and customers with quality care. We will bill your insurance as a courtesy to you. We accept most PPO insurance plans and this is required as part of our contract with the insurance company. We do not accept any discount plans, HMO or DMO plans. Upon completion of treatment we will submit your claim. You will be responsible for your estimated portion on the date of your visit.

We give all of our patients an estimate of cost prior to completing treatment. In some cases, this is written and in some cases it is verbal. We do our very best to estimate your insurance payment to be as accurate as possible. Our estimates are based on information provided to us by your insurance company. Your payment may vary from the estimate provided to you by our office if there is a restriction, declaration, or clause in your insurance contract.

Please understand that the insurance policy is a contract between you and the insurance company. We will verify your insurance eligibility as a courtesy, **but it is your responsibility to know and understand your coverage.** Any service completed at a wink & a smile is your complete financial responsibility. We will file all primary and secondary insurance claims. Any balance on the account is due upon receipt of the statement. Any late or unpaid invoices/statements will be charged interest and late fees. If your account becomes past due (over 90 days) and we require a third party collections company, you will be liable for all fees associated with the transfer of account, court costs, late fees and interest.

Scheduling: Dental appointments are normally one hour visits, with longer appointments for more extensive treatment. Your reservation requires the presence of a doctor, an assistant, and, in some cases, a hygienist. **We require a minimum of 2 business days' notice if you need to reschedule or cancel your visit.**

As a courtesy, a wink & a smile will remind you of your upcoming appointment via Smile Reminder. Patients will receive automated phone calls, text messages, and emails to remind and confirm appointments previously made by the patient or authorized party on behalf of the patient. If at any time you or an authorized party chooses to opt-out of this service, you will be responsible for keeping all reserved appointments and **will not** receive communication from our office. Should you miss or cancel an appointment without 2 business days' notice, for any reason, you will be charged a failed reservation fee.

Short notice cancellation and failed reservation fees start at \$100 for hygiene appointments and \$250 for appointments with the doctor per hour. Reservation fees for VISION are \$90.

a wink & a smile employs camera surveillance for safety of our patients, and visitors, as well as training of our staff. The equipment may or may not be monitored at any time. Persons not associated with a wink & a smile will not have access to any surveillance footage without court orders for privacy reasons. All surveillance follows strict HIPAA and Privacy Practices.

By signing this document, I agree to a wink & a smile policies and understand it is subject to change without notice.

SIGNED: _____ DATE: _____

Patient's Name: _____ Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT (Please see the attached laminated copy)

I acknowledge that I received a copy of Notice of Privacy Practices. A personal copy of this document can be made available to you at your request.

SIGNED: _____ DATE: _____

Patient's Name: _____ Relationship to Patient: _____

a wink & a smile

20745 Williamsport Place, Suite 120

Ashburn, VA 20147

571.333.1250

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

PATIENT NAME: _____

I authorize the professional office of a wink & a smile to release health information identifying me, including- if applicable, information about HIV infection or AIDS, information about substance abuse and/or-treatment, and information about mental health under the following terms and conditions:

1. Detailed description of the information to be released: **a wink & a smile ONLY releases treatment or related information to your insurance company.**
2. To person(s) identified by the patient:
 Name: _____ Relationship to Patient: _____
 Name: _____ Relationship to Patient: _____
3. Expiration date or event relating to the individual or purpose for the release.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. a wink & a smile, however, cannot submit any claims to any insurance company should you refuse to sign which will result in full office fees due at the time of service for any completed treatment.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient:

Print Name: _____ Relationship to Patient: _____



Return Policy

For Prescription Eyewear Patients:

At a wink & a smile, our optometrist(s) will perform a complete and thorough eye exam resulting in the best prescription to fit your needs. In the unlikely event that your prescription is slightly off, or you are otherwise unhappy with the lenses that have been placed in your chosen frames, the optical laboratory will redo your prescription lenses once within the first thirty (30) days after the receipt of your frame, free of charge. Any issues brought to our attention after the first thirty days will not be covered by the lab or our office. After the initial thirty day period, the expense for replacing the lenses will be the patient's responsibility. Frames cannot be returned once they have left the office. If there is a manufacturing defect, we can often use the warranty to replace them with the exact same model within one year of your purchase.


Our staff will do our best to dispense our patients' new prescription eyewear in a timely manner. However, under certain insurance policies, we are unable to use our preferred lab and have no control over the amount of time it takes to receive your eyewear. We are able to give rough estimates of the time it will take to receive your eyewear, however, we will not be able to offer a refund in the event it takes the lab longer than expected to return your eyewear. You will receive notifications your eyewear is ready via email or text. Should you opt-out of this option, it is your responsibility to check the status of your eyewear.

For Contact Lens Patients:

Most insurance plans allow for the use of benefits for either contact lens exams with a supply of lenses or frames and lenses. Please be sure to maintain the follow-ups recommended by the doctor. In the event that more than thirty (30) days has passed since the initial contact lens fitting, a new exam and contact lens fitting may be needed and the cost of these services will be the responsibility of the patient. Should the patient is not able to adapt to contact lenses and wishes to use their benefits for glasses instead, they will be responsible for the contact lens exam fitting fee which is a separate charge from the standard eye health exam. **If you have any questions about this, please address your concerns before the exam.** The contact lens exam fee represents services already rendered and is non-refundable. There are no refunds on contacts since they are designed to specifically fit your eyes.

Waiver for lens replacement in USED frames:

a wink & a smile always strives to return eyeglasses in excellent condition. In some cases, older glasses could have damaged or stressed areas that could cause breakage during lens replacement. Due to this condition, we cannot be responsible for any defects that could result from prior damage or normal wear and tear.

 We are more than happy to adjust your glasses to best suit you. a wink & a smile is not responsible for any damage caused to frames not purchased in our office within the last year.

By signing this document, I agree to the Return Policy of a wink & a smile and understand it is subject to change without notice.

SIGNED: _____ DATE: _____

Patient's Name: _____ Relationship to Patient: _____



a wink & a smile eye and dental care

Visual Field Testing

During a routine eye exam, it is recommended that patients have a visual field test to assess the potential presence of blind spots, which could indicate eye diseases. A blind spot in the field of vision can be linked to a variety of specific eye diseases, depending on the size and shape of the blind spot.

Many eye and brain disorders can cause visual field abnormalities. Examples of this include: optic nerve damage caused by glaucoma, optic nerve damage from disease, toxic exposure or damage to the retina (the light-sensitive inner lining of the eye). Additionally, visual field testing can reveal brain abnormalities caused by strokes and tumors.

Visual Field Tests are not covered by vision insurances, but are still highly recommended, especially for patients over the age of forty.

- Yes, I authorize the administration of the Visual Field Test today. **The fee for this test is \$80.00.** I accept financial responsibility for this additional vision test.
- No, I would prefer not to have the Visual Field Test at this time.

Signature: _____ Date: _____

Print Name: _____