A to Z Dental Studio

10555 Main St. Suite 150 Fairfax, VA 22030
(571) 789-12132

Patient Information

Patient Name: _____Date: _____

Social Security#: _____Gender: ____ Family Status _____DOB: _____
Phone (Home): _____(Work): _____Ext: ____Cell #_____
Email Address: _____May we contact you by email: Y or N
Address: _____
Street Apt#
_____
City State Zip Code

Health Information

Date of Last Dental Visit:_____ Reason for this visit:_____

Please circle that applies to you: _____

□ AIDS	□ Excessive Bleeding	□Liver Disease	□ Stroke
□Allergies _____	□ Fainting	□ Mental Disorder	□ Tuberculosis
_____	□ Glaucoma	□ Nervous Disorders	□ Tumors
□Anemia	□ Growths	□ Pacemaker	□ Ulcers
□Arthritis	□ Hay Fever	□ Pregnancy	□Venereal Disease
□ Artificial bones	□Head injuries	Due Date_____	□Codeine Allergy
□ Asthma	□Heart Disease	□ Radiation Treatment	□Penicillin Allergy
□ Blood Disease	□Heart Murmur	□ Respiratory Problems	□OTHER:_____
□ Cancer	□ Hepatitis	□Rheumatic Fever	_____
□Diabetes	□High blood pressure	□Rheumatism	
□ Dizziness	□Jaundice	□ Sinus Problem	
□ Epilepsy	□Kidney Disease	□Stomach Problems	

- Have you ever had any complications following dental treatment? □Yes □No
  If yes explain_____
- Have you been admitted to a hospital or needed emergency care during the past two years? □Yes □No
  If yes explain_____
- Are you now under the care of physician? □ Yes □ No
  Name of physician:_____Phone_____
- Do you have any health problems that need further clarification? □ Yes □ No
  If yes, please explain_____

- List and dosage of medication currently taking: _____

To the best acknowledgement all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature_____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? _____

Name of Person or office referring you to our practice: _____

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Spouse or Responsible Party Information

The following for: □ the patient's spouse □ the person responsible for payment

Name : _____

□ Male □ Female □ Married □ Single □ Child □ Other

Social Security#:_____Birth Date:_____

Phone(Home): _____(work):_____Ext: ____ Best time to call_____

Address:_____

Street Apartment #

_____

City State Zip Code

Employment Information

The Following is for: □ the patient □ the person responsible for payment

Employer Name: _____ Occupation: _____

Address:_____

Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____Is insured a patient? □ Yes □ No

Insured's Birth Date: _____ID#_____Group#_____

Insured's Address:_____

Street City State ZipCode

Insured's Employer Name: _____

Address:_____

Patient's relationship insured: □ Self □ Spouse □Child □Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____Is insured a patient ? □ Yes □ No

Insured's Birth Date: _____ID#_____Group#_____

Insured's Address:_____

Street City State ZipCode

Insured's Employer Name: _____

Address:_____

Patient's relationship insured: □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies ad will credit any such collections to the patient's account. However, this dental office cannot render services on assumption that our charge will be paid by an insurance company.

An interest charge of 24% per annual (2% per month) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period 90 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assigned, at the time of said services are rendered. I further agreed to pay all costs and attorney fees in t he amount of 35% of the principle amount owed, if my accounts referred to an attorney for collection.

I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____Date :_____Relationship to Patient_____

Signature of patient, parent or guardian

_____Date:_____Relationship to Patient_____

Signature of guarantor of payment/ responsible party