

**PATIENT INFORMATION**

PATIENT'S NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ SEX: M F BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ If Patient is a Minor, give Parent's or Guardian's Name \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

Who May We Thank for Referring You to our Office? \_\_\_\_\_ Reason for this Visit \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

RESIDENCE Street \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

MAILING ADDRESS Street \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

HOW LONG AT THIS ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

PREVIOUS ADDRESS (if less than 3 yrs.) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ How Long \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ NO. YEARS EMPLOYED \_\_\_\_\_

**RESPONSIBLE PARTY'S SPOUSE**NAME \_\_\_\_\_  
LAST FIRST MIDDLEEMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ ( )  
NO. YEARS EMPLOYED

SOC. SEC. # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

HOME PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_

WORK PH. \_\_\_\_\_ E-MAIL \_\_\_\_\_

**EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY, STATE \_\_\_\_\_

HOME PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_

WORH PH. \_\_\_\_\_

**DENTAL INSURANCE INFORMATION (Primary Carrier)**

Insured's Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

**If you have double dental insurance coverage, complete this for the second coverage.**

Insured's Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

***It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.***

DENTAL HISTORY		MEDICAL HISTORY	
	YES	NO	
HOW LONG SINCE you have seen a dentist?			Do you have any CURRENT HEALTH PROBLEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO
Last COMPLETE Dental Exam, Date:			Are you under a PHYSICIAN'S CARE now? <input type="checkbox"/> YES <input type="checkbox"/> NO
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)			For what?
Are you having PROBLEMS now? <input type="checkbox"/> YES <input type="checkbox"/> NO			What MEDICATIONS are you currently taking?
WHAT?			Have you ever taken Fen-Phen/Redux? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is your present dental health POOR? <input type="checkbox"/> YES <input type="checkbox"/> NO			Are you PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you wear DENTURES? (Partials or Full) <input type="checkbox"/> YES <input type="checkbox"/> NO			Do you use cigars/cigarettes, pipe or chewing tobacco? (circle) <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you UNHAPPY with your dentures? <input type="checkbox"/> YES <input type="checkbox"/> NO			<b>PLEASE YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:</b>
Would you like to know more about PERMANENT REPLACEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			AIDS/HIV Pos. <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you APPREHENSIVE about dental treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO			Anaphylaxis <input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had any PERIODONTAL (GUM) treatments? <input type="checkbox"/> YES <input type="checkbox"/> NO			Fainting <input type="checkbox"/> YES <input type="checkbox"/> NO
Do your gums BLEED, or feel TENDER or IRRITATED? <input type="checkbox"/> YES <input type="checkbox"/> NO			Food allergies <input type="checkbox"/> YES <input type="checkbox"/> NO
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle) <input type="checkbox"/> YES <input type="checkbox"/> NO			Glaucoma <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you UNHAPPY with the APPEARANCE of your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO			Headaches <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you aware of GRINDING or CLENCHING your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO			Heart murmur <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have HEADACHES, EARACHES, or NECK PAINS? <input type="checkbox"/> YES <input type="checkbox"/> NO			Heart problems (please describe) <input type="checkbox"/> YES <input type="checkbox"/> NO
Have you worn BRACES on your teeth (ORTHODONTICS)? <input type="checkbox"/> YES <input type="checkbox"/> NO			Shingles <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have DISCOLORED teeth that bother you? <input type="checkbox"/> YES <input type="checkbox"/> NO			Shortness of breath <input type="checkbox"/> YES <input type="checkbox"/> NO
Would you like your smile to LOOK BETTER or DIFFERENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			Skin rash <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you REGULARLY use DENTAL FLOSS? <input type="checkbox"/> YES <input type="checkbox"/> NO			Spina Bifida <input type="checkbox"/> YES <input type="checkbox"/> NO
Name of Previous Dentist?			Stroke <input type="checkbox"/> YES <input type="checkbox"/> NO
City: _____ State: _____			Surgical implant <input type="checkbox"/> YES <input type="checkbox"/> NO
How do you feel about your teeth?			Swelling of feet or ankles <input type="checkbox"/> YES <input type="checkbox"/> NO
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.			Thyroid disease or malfunction <input type="checkbox"/> YES <input type="checkbox"/> NO
FEAR of pain # _____ LACK of concern # _____			Tobacco habit <input type="checkbox"/> YES <input type="checkbox"/> NO
COST of treatment # _____ MISSING work time # _____			Tonsillitis <input type="checkbox"/> YES <input type="checkbox"/> NO
			Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO
			Ulcer/Colitis <input type="checkbox"/> YES <input type="checkbox"/> NO
			Venereal disease <input type="checkbox"/> YES <input type="checkbox"/> NO
			<b>ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?</b>
			Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves, etc.)
			Nitrous Oxide Codeine Penicillin
			Are you aware of being allergic to any other medications or substances?
			If yes, list:
			<i>Is there any other Medical or Dental information that you feel I should know about?</i>
			FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

PATIENT Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_ DENTIST Signature \_\_\_\_\_

# **VIENNA DENTAL CARE**

SHAHRAM SABET D.D.S., P .C.

360 W. MAPLE AVE., UNIT C  
VIENNA, VIRGINIA 22180  
(703) 281-1311

EFFECTIVE JUNE 12, 2007

## **Fees and Payments**

**Fees** - Payment for services must be made by one of the following options.

**Per Appointment** -If you are not covered by an insurance plan, full payment is due at the time service is rendered. We accept Cash, Check, Visa, MasterCard, Discover and American Express. Please note there will be a fee of \$30.00 for returned checks.

**CO-PAYMENT** - We will estimate your co-payment based on the most current information provided by your insurance carrier. Co-payment is due at the time of your visit.

You must understand that YOUR DENTAL INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER AND NOT BETWEEN THE INSURANCE CARRIER AND THE DOCTOR. YOU ARE FULLY RESPONSIBLE FOR ALL DENTAL FEES EVEN IF YOUR CARRIER DENIES OR EXCLUDES COVERAGE. We are only able to estimate your benefits and it is not Q guarantee of payment.

**Insurance Assignment** - Our office will submit to your insurance company for services rendered at the time of your visit.

## **Cancellations and Missed Appointment Charges**

Broken appointments are not fair to any of the parties involved. They deny other patients the use of this time, they cost the practice money as staff salaries and other expenses continue. They make our office hesitant to appoint that patient again. Our practice does not profit from these charges. We merely cover expenses for our time that was set aside for you.

In order to recoup and recover expenses incurred by broken appointments we charge **\$60.00** per hour. These charges are assessed to patients that have not given our office 48 "business day" hours notice.

## **Interest. Late Charges & Non-Payment**

**Interest** - Interest will be charged at a rate of 1.5% per month on the current amount due. Interest is not charged on amounts due from your insurance carrier.

**Late Charges** - When current patient balance is due, is not paid by the due date, late fees and interest are added to the account.

**Non-Payment** - This office reserves the right to place any delinquent account with a collection agency. You agree to pay any and all fees associated with this process including but not limited to collection cost, attorney's fees and/or court cost if necessary.

Please be aware that your account with our office is not a revolving credit line. We assist with insurance as a courtesy only. All fees are due and payable upon demand. In the event of any and all disputes with the insurance carrier fees must be paid to the office. You are responsible for disputing insurance company liability directly with your carrier. Our office will provide documentation only. In the event the insurance company wants documentation beyond codes provided by the American Dental Association Current Dental Terminology, additional documentation fees may be charged.

## **Transfer of Patient Records**

Your request to transfer your dental records should be submitted in writing. We will copy your current x-rays and mail them certified to a dentist of your choice. The fee is \$25.00 per family.

If you have any questions please ask our Office Manager for assistance.

**By your signature it is understood and agreed that you are directly responsible for payment for the services rendered whether or not your insurance is involved. If it becomes necessary to go outside the office to any agency for the collection of fees you will be charged for the additional expenses.**

**Patient or Guarantor** \_\_\_\_\_

**Date** \_\_\_\_\_

Virginia State Testing Law

Pursuant to Virginia Law 32.1-45.1- Any patient who exposes a health care provider or his employee/agent to body fluid in a manner which may transmit the human Immunodeficiency virus (HIV), Hepatitis B or C virus is deemed to have consented to HIV, hepatitis B and C testing and disclosure of the result to the person exposed this deemed consent also applies to a health care provider who exposes a patient to body fluid in the above stated .manner.

Print Patient's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

I HAVE READ AND ACKNOWLEDGE THE  
HIPPA PRIVACY PRACTICE STATEMENTS

SIGNATURE \_\_\_\_\_