

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
Last First MI

**1. ABOUT PATIENT**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female  
 Driver Lic. #: \_\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Driver license expiration: \_\_\_\_/\_\_\_\_/\_\_\_\_ State: \_\_\_\_\_  
 \_\_\_\_\_  
 Home address  
 \_\_\_\_\_  
 City State Zip  
 \_\_\_\_\_  
 Home phone Cell phone  
 \_\_\_\_\_  
 Email address  
 \_\_\_\_\_  
 Status:  Minor  Single  Married  Widowed  Divorced  
 If married, spouse's name: \_\_\_\_\_  
 Do you have children:  Yes  No \_\_\_\_\_  
 If yes, how many?  
 Employer: \_\_\_\_\_ How long? \_\_\_\_\_  
 \_\_\_\_\_  
 Employer's address  
 \_\_\_\_\_  
 Employer's City State Zip  
 \_\_\_\_\_  
 Work phone Occupation

**2. EMERGENCY CONTACT**

\_\_\_\_\_ Last Name First MI  
 Relation:  Spouse  Parent/Guardian  \_\_\_\_\_  
 \_\_\_\_\_  
 Phone (Home / Work) Cell Phone  
 \_\_\_\_\_  
 Primary Physician Name: \_\_\_\_\_  
 Primary Physician Phone: \_\_\_\_\_

Whom may we thank for referring you to our practice?  
 Another Patient: \_\_\_\_\_  
 Relationship:  Family  Friend  Neighbor  \_\_\_\_\_  
 walk-in  Newspaper add  Insurance  News Letter  Online  
 Loudoun Chamber of Commerce  Yellow Pages  \_\_\_\_\_

**3. ACCOUNT INFO**

Person ultimately responsible for account (other than patient):  
 \_\_\_\_\_  
 Last Name First MI  
 Relation:  Self  Spouse  Parent/Guardian  \_\_\_\_\_  
 \_\_\_\_\_  
 Billing address (if different from home address)  
 \_\_\_\_\_  
 Billing City State Zip  
 SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: \_\_\_\_\_  
 Driver Lic. #: \_\_\_\_\_ State: \_\_\_\_\_  
 Driver license expiration: \_\_\_\_/\_\_\_\_/\_\_\_\_

**4. INSURANCE INFO**

\_\_\_\_\_ Last Name First MI Date of Birth  
 Primary insurance holder:  Self  Spouse  Parent/Guardian  
 \_\_\_\_\_  
 Insurance provider ID number  
 \_\_\_\_\_  
 Insurance type Group number  
 \_\_\_\_\_  
 Insurance address Insurance phone number  
 \_\_\_\_\_  
 Insurance City State Zip  
 \_\_\_\_\_  
 Employer's name  
 \_\_\_\_\_  
 Employer's address  
 \_\_\_\_\_  
 Employer's City State Zip

Dental benefits are designed to assist you in some of the cost of your dental treatment. Some Insurance is subject to annual deductible and pays a portion of your treatment up to a modest annual maximum limit. It is your responsibility to know what your Dental Insurance covers, and your annual deductible and limit.

We will do our best to see that you receive your full benefits. However, ultimate responsibility for payment is yours and financial arrangements must be defined before dental treatment begins. Your portion is payable on day of treatment.

Emergency cases will be handled by the patient paying for treatment at the time of service, and your insurance will reimburse you.

**We DO NOT file secondary insurances.** That is the patient's responsibility, however, the proper paperwork will be provided to our patients in order for them to file with their secondary insurance.



Patient Name: _____	Date of Birth: ____/____/____	Age: _____
Last	First	MI

**Your First Visit**

Your initial first visit involves get to know you, the problem you are experiencing and your dental needs. In addition, by sharing your general health information with the doctor, be sure to provide complete, up to date information on your health. Inform the doctor if you recently been ill, or have experienced recent hospitalization or surgery. Be sure to tell the doctor the names, doses, and frequency of any medications you are taking; whether prescription or over the counter products. If you are under care of a physician, be sure to provide the physician name and contact information. Health problems that you may have, or medications you may be taking, could have an interrelationship to your oral health.

If this is your first time visit to a dentist, or you do not have any up to date copies of your dental records and X-Ray from your previous dentist. We will be taking a full mouth X-Ray to have an over view of your oral health.

After your initial appointment and reviewing your X-Ray's, a treatment plan will be initiated for your consultation visit. This will give you ideas on what type of treatment you may need, the cost and any insurance coverage.

Also, be sure to bring in your insurance card when applicable, and your driver's license to your appointment.

**Appointment Policy**

Patients are seen by appointment only. Our office reserves one (1) hour for an adult checkup, and thirty (30) minutes for children under the age of twelve (12). Special cases and additional complications may take longer. We make every effort to be on time for our patients, and ask you to extend the same courtesy to us and other patients.

We strive to have timely appointments available to patients that need to be seen quickly. Therefore, we need to know if you are unable to keep an appointment **no less than twenty-four (24) hours**, so that we may offer that time to someone who has an immediate need. **As a result, there will be a \$50.00 cancellation fee for every thirty (30) minutes allocated for your treatment plan.**

**We require no less than forty-eight (48) hours cancellation notice for Saturday appointment. As a result, there will be a \$100.00 no-show fee for every thirty (30) minutes allocated for your treatment plan.**

If you are very late for an appointment and there is not enough time remaining in the schedule to complete your planned treatment before our next patient is due, we may need to reschedule your appointment. **In any case, the cancellation fee may apply.**

Certainly emergencies such illness do occur and we do not wish to penalize patients for unavoidable situations; however, we do want to discourage repeated abuse of our scheduling process, which is ultimately unfair to those who are diligent about keeping their appointment.

**Finance and Insurance Policy**

As a condition of treatment by our practice, ultimate responsibility for payment is yours and is paid in **FULL**, less estimated insurance, is expected at time of service unless prior arrangements have been made.

**For your convenience**

1. We accept payment by cash, check, debit, and credit cards (Visa, MasterCard, American Express and Discover).
2. For treatment plans over \$350 and qualified patient, we provide an authorized monthly auto charge to your Visa or Master Card for a period of 2 to 4 months at no additional cost. (this offer is limited time)
3. We provide Fee for Service payment courtesy discount from 3% up to 10%, depending on treatment plan and type of payment method.
4. Interest free financing: For treatment plans over \$500 you can apply for an interest free loan with fixed payments for a period of 6 to 12 months. Longer terms are also available. We can give you an instant approval with a simple credit application.

**Late payment and returned check**

1. A service charge of 1½% per month (18% per year) and a dept recovery charge of \$25.00 will be charged on unpaid balances exceeding 60 days.
2. In the event that your account must be sent to a collection agency for none-payment, you will be responsible for all cost of collection fees, court fees and attorney fees.
3. A \$35.00 service charge will be added to your account for all returned checks.

**Dental insurance**

Dental benefits are designed to assist you in some of the cost of your dental treatment. Some insurance is subject to annual deductible and pays a portion of your treatment up to a modest annual maximum limit. It is your responsibility to know what your Dental Insurance covers, and your annual deductible and limit.

We will do our best to see that you receive your full benefits. However, ultimate responsibility for payment is yours and financial arrangements must be defined before dental treatment begins. Your portion is payable on day of treatment. **Emergency cases** will be handled by the patient paying for treatment at the time of service, and your insurance will reimburse you.

**We DO NOT file secondary insurances.** That is the patient's responsibility, however, the proper paperwork will be provided to our patients in order for them to file with their secondary insurance.

Remember, your insurance policy is a contract between your employer and your employer's insurance company—we are not party to that agreement. Therefore, our office cannot accept responsibility for negotiating a settlement with your insurance company on a disputed claim.

<b>Consent</b>	
We invite you to discuss with us any questions or concern you may have regarding our policy and services. The best dental health services are based on a friendly mutual understanding between patient and provider.	
I understand that the fee estimate for dental care can only be extended for a period of sixty (60) days from the date of my examination. This includes any special discount or offer introduced to me.	
I grant my permission to the staff of this office, to telephone me at home, mobile phone, or at my work to discuss matters related to my oral health and information given in this form.	
I authorize the staff of this office to perform any necessary services needed during diagnosis and treatment. I also authorize the staff of this office to release any information required by my insurance company to process insurance claims.	
I have read and understand the above office policy and conditions of treatment and payment, and agree to their content. I also guarantee all required forms were completed correctly to the best of my knowledge.	
_____ Signature of patient, parent or guardian	Date: ____/____/____ Relationship to Patient: _____
_____ Signature of guarantor of payment/responsible party	Date: ____/____/____ Relationship to Patient: _____