Leesburg Premier Dental 703-687-4861
www.leesburgpremierdental.com

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date_____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

E-Mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

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

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

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

To the best of my knowledge, 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.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Spouse or Responsible Party Information

The following is 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: _____

Insurance Information

Primary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Assignment of Benefits

I authorize payment of benefits to Leesburg Premier Dental for dental services provided.

_____
Signature Date

Release of Information

I authorize the release of any dental Information necessary to process claims.

_____
Signature Date

Authorization to Release Healthcare Information

Patient Name: _____
Last First

Legal Guardian Name:_____Birth Date: _____
Last First

I Request and authorize Leesburg Premier Dental to release personal health information of the above patient to:

Name: _____ Birth Date: _____
Last First

Address:_____
Street Apt# City State Zip Code

We may also E-mail X-Rays (if you can accept e-mail please indicate address)

E-Mail Address: _____

Reason for Request: ☐ Referral for specific purpose ☐ Second Opinion ☐ Transferring Providers ☐ Other

Please send indicated items: ☐ X-rays ☐ Treatment records

This request and authorization applies to healthcare information relating to treatment and conditions. Pursuant to the Federal Law, this request must be fulfilled within 21 business days of request. There is a change of $0.65 per page plus any applicable postage fees for the duplication of records.
Once my doctor gives out the information that I released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or State privacy laws may no longer protect the information.

Signature of patient or patient's authorized representative _____ Date_____

Relationship to patient if signed by parent or representative_____

Patient's 18 years or older MUST sign their own form.

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 and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) 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 of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my 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

Financial Policy

Thank you for choosing our team of dental professionals to serve your dental needs. We are committed to provide you with the highest quality care. We appreciate the confidence you have placed in us and will do everything possible to continue to warrant your confidence as we serve you. In order to continue providing outstanding care to all of our patients, we ask that you please understand and agree to the following office financial policy.

Insurance:

Dental insurance is designed to help offset cost of dental care, Insurance estimates provide a table of allowance that will assist you in determining your approximate out-of-pocket expenses.

1. Filling insurance claims is a courtesy that we will gladly perform for you to help you maximize your benefits, However, you are responsible for any amount not covered by your insurance, whatever the reason.
2. On your behalf, we will contact your insurance company to help determine your level of benefits. Please note that insurance estimate and pre-estimates are *not a guarantee* from your insurance company.
3. Your insurance policy is a contract between your employer and your employer's insurance company, we are not party to that agreement. Our office cannot accept responsibility for negotiating a settlement with your insurance company on a disputed claim.
4. We generally will accept assignment of benefits (payment) from your insurance company but we reserve the right to refuse assignment on certain plans. In that case full payment is due by you at the time of service and your insurance company will reimburse you directly.
5. In the event that you wish to have us invoice your insurance company directly, you are agreeing to the following statement: I request the payment of authorized insurance benefits for any services furnished to me be made on my behalf to Leesburg Premier Dental.

Missed Appointment Fee: Leesburg Premier Dental does charge a missed appointment fee of $30.00 per half hour of appointment time for all appointments not given at least two business days (48hrs) advance notice. Please call us immediately once you realize that you cannot keep your appointment. All missed appointment fees MUST BE *paid prior to scheduling another appointment.*

Payment Policies:

As a condition of your treatment by this office, financial arrangements must be in advance. We depend upon payment from our parties for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment. We will discuss financial options with you before rendering treatment.

1. If you have dental insurance, you estimated portion of payment is due in full at time of service, unless prior written financial arrangements have been made.

2. If you do not have dental insurance, payment for services is due in full at time of service, unless prior written financial arrangements have been made.

3. There is a $35.00 service charge on all returned checks.

4. I understand and agree that any account balance not paid within 90 days must be subject to collection activity. I understand Leesburg Premier Dental will retain the services to assist with the collection of any outstanding balance.

By signing below you are agreeing to all of the terms contained in this Financial Responsibility Agreement and Consent for services.

Print Patient Name: _____(Please Print)

Signature/ Guardian: _____ Date:_____

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