**Patient Information**

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home number\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_ZipCode\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last Physical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Male \_\_Female\_\_Single\_\_Married\_\_Divorced\_\_Widowed

SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party/Insurance Information**

Person responsible for account\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental History

1. When did you have your last dental exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Was restorative treatment recommended: Yes\_\_\_\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_
3. How often do you brush your teeth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you floss? Yes\_\_\_\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Do you wear an appliance? Yes\_\_\_\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Health Questionnaire**

Are you being treated by a physician at this time? Yes\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any drug allergies? Yes\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have or ever had any of the following? (circle all that apply)

Heart Disease Tuberculosis Radiation Therapy Kidney Disease

Heart Murmur Diabetes Chemotherapy Mitral Valve Prolapse Psychiatric Treatment

Asthma Epilepsy Sinusitis Venereal Disease Liver Disease

Pacemaker Hepatitis Glaucoma High Blood Pressure

Anemia GI Ulcer Hepatitis Bleeding Problems Severe Pain

AIDS Glaucoma Arthritis Rheumatic Fever

Cancer Low Blood Pressure

Prosthetic Joints\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE**

Please understand that as a dental care provider our relationship is with you and not with your insurance company. Filing of insurance claims is a courtesy that we extend t o our patients, but all charges are our responsibility from the date services are rendered. We have no leverage on assuring that your claims are paid. Our office is not responsible for collection your insurance claim or for negotiation disputed claims. We invite you to bring your policy booklet with you and we will be happy to assist you in understanding your coverage.

**ASSIGNMENT AUTHORIZATION/RELEASE OF AUTHORIZATION**

I, the undersigned, hereby authorize Reston Stations Dental and/or its agents to apply for benefits on my behalf for services rendered to my dependents or me. I request payment form my insurance carrier be made directly to Reston Station Dental and in cases where the carrier had made payments directly to me, I will return funds to Reston Station Dental in a timely fashion. I also certify that the information on this form is correct and further authorize the release of any information for any claim to my insurance carrier. I agree that a copy of this signed release and f my records may be used in lieu of the original and authorize its release to all parties involved in my care and care of my dependents.

**GUARANTEE OF PAYMENT/NON-COVERED CHARGES**

I, the undersigned ,understand and agree that I am financially responsible for all charges including those not covered by my dental insurance policy. Payment is due at the time services are rendered. I agree that it is a matter between me and my insurance carrier whether or not the insurance company pays Reston Station Dental all, a portion or none of the claim submitted on my behalf. I understand that if services are denied by my insurance carrier then it is my responsibility to pay for these charges. Regardless of my insurance situation, I understand that I am responsible for any balance due.

In the event that my account must be placed with an attorney or collection agency, I agree to pay attorney fees in the amount of thirty three and one third percent of the unpaid balance, any court costs and interest in the amount of eighteen percent per annum.

I further understand that I will be charged $50 for every scheduled appointment hour that I Cancel or miss without giving 24 hours’ notice.

Signature of Patient of Responsible Party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent of guardian if patient is a minor)