PATIENT REGISTRATION AND MEDICAL HISTORY

Date________________ (PLEASE PRINT) Home Phone________________

Patient____
Last Name First Name Initial Preferred Name

Street Address________________ City________ State________ Zip________

Sex: ☐ M ☐ F Age________ Birthdate________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by________________________ Occupation________________

Business Address________________________ Business Phone________________

Spouse/Parent Name________________________ Spouse/Parent Birthdate________________

Spouse/Parent Employed by________________________ Occupation________________

Business Address________________________ Business Phone________________

Who is responsible for this account?________________________ Relationship to Patient________________

Social Security #________________ Spouse/Parent Social Security #________________

Name of Dental Insurance Company________________________ Group Number________________

In case of emergency, who should be notified?________________________ Phone________________

Whom may we thank for referring you?________________________________

MEDICAL HISTORY

Physician's Name________________________ Date of Last Physical________________

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ "A.I.D.S." or Other Immunosuppressive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?________ If so, what________________

____

Have you ever responded adversely to medical or dental treatment?________________________

Are you taking any medication at this time?________ If so, what________________________

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions?________________________________

If patient is a child, what is his/her weight?________________________

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history?________________________

____

____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date________________ Signature________________________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with____
Name of Insurance Company(ies)

and assign directly to Dr.______________________________ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_______________ ____
Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of__________________________________ do hereby request
Name of minor/child
and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_______________ ____
Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_______________ ____
Date *Signature of Insured/Guardian*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?____

Are you taking any new medications?________ If so, what ______________________________

_______________ ____
Date *Patient Signature*

_______________ ____
Date *Dentist Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?____

Are you taking any new medications?________ If so, what ______________________________

_______________ ____
Date *Patient Signature*

_______________ ____
Date *Dentist Signature*

DR. SAWSAN ABOUSY & ASSOCIATES

OFFICE POLICY

1) CO-PAYMENT IS DUE AT THE TIME OF SERVICE
2) APPOIMENTS MUST BE CANCELLED OR RESCHEDULED AT LEAST 24 HOURS IN ADVANCE. A CANCELLATION FEE OF $25.00 WILL BE CHARGED IF ADVANCE NOTICE IS NOT GIVEN.
3) IT IS THE PATIENTS RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN ADDRESS OR INSURANCE INFORMATION PRIOR TO ANY VISIT, FAILURE TO DO SO WILL MAKE THE PATIENT RESPONSIBLE FOR ANY PAYMENT FOR THAT VISIT.
4) IT IS YOUR RESPONSIBILITY, AS A PATIENT, TO KNOW THE BENEFITS COVERED BY YOUR DENTAL INSURANCE. THIS INCLUDES THE FACT THAT INSURANCE COMPANIES DO NOT GUARANTEE ANY PAYMENT UNTIL THE CLAIM IS SUBMITTED. AN EXPLANATION OF BENEFITS WILL BE SENT TO YOU BY THE INSURANCE COMPANY AFTER APPROVAL OF THE CLAIM.
5) THE CO-PAYMENT THAT IS CHARGED BY THE OFFICE IS AN ESTIMATE. YOU WILL BE EITHER REFUNDED OR CHARGED AFTER YOU AND THE OFFICE RECEIVE THE EXPLANATION OF BENEFITS.
6) OTHER CHARGES SUCH AS STERILIZATION FEE OR AN OFFICE VISIT MAY BE CHARGED ONLY WHEN IT IS ALLOWED BY YOUR INSURANCE AND PRESENT IN THE FEE SCHEDULE.
7) IF YOU HAVE ANY QUESTIONS REGARDING YOUR CO-PAYMENT OR CHARGES BILLED, PLEASE CONTACT OUR OFFICE.

I, ACKNOWLEDGE THE STATEMENT ABOVE.

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____________________________