Smiles Of Loudoun
DENTISTRY

We are please to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Name: _____
Last, First M.I. (Preferred)

Address: _____
Street City, State Zip Code

Birthdate:_____ SS# _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Wireless Phone: _____ Home Phone : _____ Work Phone: _____

Email: _____ *How did you hear about us*:_____

Preferred contact method: ☐ Wireless Phone ☐ Work Phone ☐ Email
Preferred contact method for confirmations: ☐ Wireless Phone ☐ Work Phone ☐ Email
Student Status if dependent over 19 (for ins): ☐ Non Student ☐ Fulltime ☐ Part Time

Emergency Contact : _____ _____ _____
Name Relationship Phone Number

Primary Insurance/ Medical Insurance

Insurance Company:_____ Identification Number :_____
Insurance Phone: _____ Group Name:_____ Group #: _____
Subscriber Name:_____ Subscriber DOB:_____
Your relationship to subscriber: ☐ Self ☐ Spouse ☐ Child / Dependent

Secondary Insurance

Insurance Company:_____ Identification Number :_____
Insurance Phone: _____ Group Name:_____ Group #: _____
Subscriber Name:_____ Subscriber DOB:_____
Your relationship to subscriber: ☐ Self ☐ Spouse ☐ Child / Dependent

_____ _____
Patients Name Printed Date

_____ _____
Patient/Guardian Signature Date

Smiles of Loudoun
430 Harrison St. SE
Leesburg, VA 20175
(571)510-3034
SmilesofLoudoun.com

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Medical History for New Patient

Name of Medical Doctor: _____ Phone: _____ City/State: _____

Emergency Contact: _____Phone: _____ Relationship: _____

List all medications that you are now taking:

_____ _____

_____ _____

Are you allergic to any of the following? Yes No (Please circle)

Anesthetic Aspirin Codeine Ibuprofen Iodine Latex Penicillin Sulfa None

Do you have any of the following medical conditions? Yes No (Please circle)

Allergies Asthma Cancer Diabetes Glaucoma Hepatitis Heart Murmur

High Blood Pressure History of cardiac problems HIV/AIDS Kidney, liver or blood disease

Mental Disorders Pacemaker Pregnancy/birth control/ nursing Respiratory Problems

Tuberculosis If pregnant: Due date_____

Do you take antibiotic premedication for your dental visits? _____

Describe any current medical treatment, in pending surgery, or other treatment that may possibly affect your dental treatment? _____

What is your estimate of your general heath? _____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit? _____

New patients:

Do you have a panoramic x-ray or full mouth x-rays that are less than 5 years old? _____

Do you have bitewing x-rays that are less than 1 year old? _____

Name of former dentist: _____ City/State: _____

Date of last cleaning and exam: _____

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Notice of Privacy Policies

I understand that I may inspect or copy the protected health information by this authorization.

I understand that at any time , this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of record whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so , may be subject to federal or state law protection it confidentiality.

_____ _____

Patients Name Printed Date

_____ _____

Patient/Guardian Signature Date

Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel your appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. Our staff want to be available for your needs and the needs of all of our patients. When a patient does not show up for scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for a no-show appointment and those appointments not cancelled within 24 hours. There will be a $60.00 assessed for every half hour if we do not receive a call to cancel an appointment.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

I grant permission to you or your assignee, to telephone me to discuss this statement or my treatment.

_____ _____

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Financial Policy

As a condition of treatment by the office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 collections to the patients 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 1.5% 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 any fee estimate 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 by this practice, I agree to pay the charges for the service at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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.

_____ _____

Patients Name Printed Date

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