

N R EMAD DDS PC
NOVA DENTAL CARE

307 Maple Ave W suite 100
Vienna, VA 22180

14018 Sullyfield circle Suite F
Chantilly, VA 20151

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____
Address _____ City _____ State _____ Zip _____
E-mail _____ Home Phone (____) _____ Cell Phone (____) _____
Sex M F OTHER Whom may we thank for referring You? _____

FINANCIAL INFORMATION

(if patient is under 18 years old or not in control of their mental facilities)

Name of Guarantor _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
E-mail _____ Home Phone (____) _____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of Insurance _____ Name of Insured _____
Relationship to Patient _____ Birthdate _____ policy number _____
Employer _____ Work Phone (____) _____

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AUTHORIZATION AND RELEASE I, the undersigned, hereby authorize N. R. Emad, DDS PC to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize N. R. Emad, DDS PC to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the above-named patient, and further authorize and consent that N. R. Emad, DDS PC employs such assistance as the doctor deems fit. I also understand that the use of anesthetic agents embodies a risk. I understand that payment of my bill is my legal obligation. All filings of insurance papers and confirmation of insurance payments to be made by my insurance carrier are my responsibility. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow through or confirmation. In the case that the account should become delinquent and is therefore placed in the hands of an Attorney for collection, I agree to pay attorney fees of 33.3 % of the unpaid balance, all court costs and interest (at a rate of 1.5%/month or 18% APR) beginning 30 days after the monies have become due or expenses have been incurred. I further agree to pay returned check charges of \$25.00 per returned check. I agree to pay a 4% credit card fee for all credit card purchases. I also understand and agree that I am responsible for services rendered to my spouse and/or children/dependents. Our office follows a 48-hour cancellation policy. There will be a charge of \$50 per half hour for any appointment not canceled within the required time.

Signature or Patient or Responsible Party _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved. By signing this form, you are acknowledging that Neal R. Emad DDS PC has made our Notice of Privacy Practices available to you for review, acknowledgement, and that we have offered you a personal copy. See back of the page for HIPAA ACKNOWLEDGEMENT.

Signature: _____ Date: _____

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DENTAL HISTORY

Reason for today's visit _____ Date of last dental exam _____

Date of last dental x-rays _____ How often do you floss? Brush? _____

Check if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in mouth

MEDICAL HISTORY

Physicians Name _____

Date of last visit _____

Have you had any serious illnesses or operations? Y___ N___ If yes, describe _____

(Women) Are you pregnant? Y___ N___ Nursing? Y___ N___ Taking birth control pills? Y___ N___

Check if you have or have had any of the following:

☐ Anemia	☐ Congenital Heart	☐ Lesions	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cortisone Trmt	☐ Hernia Repair	☐ Shortness of Breath	
☐ Artificial Heart Valves	☐ Cough, Persistent	☐ Mental Disorders	☐ Cough up Blood	
☐ HIV/AIDS	☐ Stroke	☐ Asthma	☐ Diabetes	
☐ Jaw Pain	☐ Swelling Feet/Ankles	☐ Back Problems	☐ Epilepsy/Seizures/ Fainting	
☐ Kidney Disease	☐ Thyroid Problems	☐ Bleeding Abnormally	☐ High Blood Pressure	
☐ Liver Disease	☐ Tobacco Habit	☐ Blood Disease/Transfusion	☐ Glaucoma	
☐ Mitral Valve Prolapse	☐ Tonsillitis	☐ Cancer	☐ Headaches	
☐ Pacemaker	☐ Tuberculosis	☐ Chemical Dependency	☐ Heart Murmur	
☐ Jaundice	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease	
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Sinus Problems	
☐ Head Injuries	☐ Mental Disorders	☐ UlcerChemo/Radiation	☐ Skin Rash Joints, Pins, etc.	

List medications you are currently taking and correlating diagnosis: _____

Allergies: _____