Neal R. Emad, D.D.S., P.C.

307-F Maple Ave W #100
Vienna, VA 22180

14018-F Sullyfield Circle
Chantilly, VA 21151

PATIENT INFORMATION

Name ________________________________ Birthdate________________ SS#________________________
Address_______________________________ City____________________ State______ Zip_____________
E-mail________________________________ Home Phone (___)________ Cell Phone (___)_____________
Sex M F Whom may we thank for referring You?____
Employer____ Employer Phone (___)_________________
Employer Address_______________________ City_______________________ State _____ Zip___________
Spouse/Parent's Name____________________ Employer_________________ Work Phone (___)__________
Person to contact in case of emergency_________________________________ Phone (___)______________

RESPONSIBLE PARTY

Name of responsible party ____________________________ Relationship to Patient______________________
Address ____ Home Phone (___)_________________________
Driver's License #___________________________________ Birthdate _________________________________
Employer ____ Work Phone (___)_________________________
Currently a patient at our office Y N E-mail ________________________ Cell Phone (___)_______________

INSURANCE INFORMATION

Name of Insured________________________________ Relationship to Patient __________________________
Birthdate _____________________ SS# _________________________ Date Employed __________________
Employer ____ Work Phone (___)_________________
Employer Address____________________________ City_______________ State__________ Zip__________
Insurance Company __________________________ Group #____________ Member ID __________________
Address _____________________________________ City _______________ State __________ Zip__________

AUTHORIZATION AND RELEASE

I, the undersigned, hereby authorize **N. R. Emad, DDS** 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** 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** employ such assistance as the doctor deems fit. I also understand that the use of anesthetic agent embodies a risk.

I understand that payment of my bill is my legal obligation. All filings of insurance papers and conformation 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 also understand and agree that I am responsible for services rendered to my spouse and/or children/dependents.

Our office follows a 24 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.

DENTAL HISTORY

Reason for today's visit____

Date of last dental exam____________________________ Date of last dental x-rays__________________________

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

How often do you floss? ________________________ How often do you brush? ____________________________

MEDICAL HISTORY

Physicians Name____________________________________ Date of last visit_________________________________

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

Have you ever had a blood transfusion? Y___ N___ If yes, approximate dates____________________

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

List medications you are currently taking and correlating diagnosis: ______________________________________
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Allergies: ____

Notes:
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