Patient Information

Patient Name: _____ Date:_____
Last First MI (Preferred Name)
Gender: _____ Family Status: _____

Social Security #: ***(OPTIONAL)***_____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work): _____Ext: _____

Address: _____
Street Apartment #

_____
City State Zip Code

How did you hear about us?_____

If you heard about us through a friend or relative, may we have their name so we may thank them?

Name:

Email Address_____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Stroke
- ☐ Heart Attack
- ☐ Penicillin Allergy
- ☐ Codeine Allergy
- ☐ Pregnancy
  Due date:_____
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Cancer
- ☐ Radiation Therapy
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Abnormal Growths
- ☐ Tumors
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Heart Surgery
- ☐ Angioplasty
- ☐ Blood Disease
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Hay Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ HIV
- ☐ Anemia

OTHER:
- ☐ _____
- ☐ _____

- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list all:_____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Spouse, Guardian or Responsible Party Information

The following is for: ☐ Spouse ☐ the patient's parent/guardian ☐ the person responsible for payment

Name: _____ Birth Date:_____

Address: _____

Phone: _____ Social Security #: _____

Authorization to Release Healthcare Information

Patient Name: _____ Birth Date:_____
Last, First

Legal Guardian Name: _____ Birth Date:_____
Last, First

I request and authorize Reston Family Dental Center/ Reston Town Center Dental (RFDC/RTC) to release personal health information of the above patient to:

Name: _____ Birth Date:_____
Last, First

Address: _____
Street Apartment # City State Zip Code

We may also E-Mail X-Rays & contact via phone for health related information:
E-Mail Address/phone # :_____

Reason for Request: ☐ Referral for specific purpose ☐ Second Opinion ☐ Transferring Providers ☐ Other
Please send indicated items: ☐ X-rays ☐ Treatment records

This request and authorization applies to healthcare information relating to treatment and conditions. Pursuant to the Federal Law, this request must be fulfilled within 21 business days of request. Once my doctor gives out the information that I released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or State privacy laws may no longer protect the information.

Signature of patient or patient's authorized representative_____ Date: __
Relationship to patient if signed by parent or representative_____

Patient's 18 years or older MUST sign their own form.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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.
Patients who carry dental insurance understand that all dental services furnished 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 such collections to the patient's 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 1½% 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 the fee estimate listed 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, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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.
In the event your account become past due and is referred to an outside collection agency attorney, you will be responsible for the collection costs at the rate of 35% of the balance due, along with reasonable attorney fees and court costs incurred by this office. You are authorizing RFDC and its partners to contact you via cell phone for the purpose of discussing treatment details with respect to your dental treatment plans. I consent to receiving appointment reminders and other healthcare communications/information by email and/or text from Reston Family Dental Center. I have read the above conditions of treatment, communication and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party.

RTC
RESTON
TOWN CENTER
DENTAL