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Patient Information

Patient Name: _____ **Date:** _____
Last First MI (Preferred Name)

Sex: ☐ Male ☐ Female **Family Status:** ☐ Single ☐ Married ☐ Widowed ☐ Other _____

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ **(Work):** _____ **Ext:** _____ **(Cell):** _____

Email: _____@_____

Address: _____
Street Apartment #

_____
City State Zip Code

Reason for this visit: _____ Who is you dentist/last dentist: _____

Please check those that apply: (MAKE SURE YOU MARK EITHER YES OR NO, DO NOT LEAVE ANY BLANK)

YES	NO		YES	NO		YES	NO	
☐	☐	Take Aspirin	☐	☐	Fainting	☐	☐	Pacemaker
☐	☐	AIDS/ HIV	☐	☐	Glaucoma	☐	☐	Pregnancy
☐	☐	Arthritis	☐	☐	Growths	☐	☐	Radiation Treatment
☐	☐	Artificial Joints	☐	☐	Gout	☐	☐	Respiratory Problems
☐	☐	Asthma (have spray?)	☐	☐	Heart Disease	☐	☐	Rheumatic Fever
☐	☐	Blood Diseases	☐	☐	Heart Murmur	☐	☐	STD
☐	☐	Bone Medication:	☐	☐	Hepatitis A, B, C	☐	☐	Sinus Problems
Aredia, Boniva,Fosamax,zometa			☐	☐	High Blood Pressure	☐	☐	Stomach Problems
Alendronate, bisphosphonates			☐	☐	Hyper/Hypo Thyroidism	☐	☐	Steroid usage
☐	☐	Bleeding problems	☐	☐	Jaundice	☐	☐	Stroke
☐	☐	Cancer History	☐	☐	Kidney Disease	☐	☐	Tobacco /smoking
☐	☐	Chemical Dependency	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	Mental Disorders	☐	☐	Tumors
☐	☐	Dizziness	☐	☐	Nervous Disorders	☐	☐	Ulcers
☐	☐	Epilepsy	☐	☐	Osteopenia/prosis	☐	☐	Any other condition?
☐	☐	Excessive Bleeding	☐	☐	Organ transplant			

Any allergies:
☐ **YES** ☐ **NO**

If yes, please list allergies:

DO YOU PRE-MEDICATE FOR DENTAL APPOINTMENTS? ☐ **YES** ☐ **NO** **FOR HEART REASONS or ARTIFICIAL JOINTS?** _____
IF YES, WHAT MEDICATIONS Amoxicillin/ clindamycin/ Keflex/other? _____

PLEASE LIST ALL PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS: _____
_____
_____

- 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 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

Responsible Party Information if the responsible party or insurer is another person (Example: parents, spouse, etc.)

Name _____ **Relationship:** _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ **(Work):** _____ **Ext:** _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment/Insurance Information

The following is for: **Insured/Responsible Party**

Employer Name: _____ **Occupation:** _____

Insurance Company : _____ Group# _____ Policy ID# _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend, or relative: _____

☐ Dental Office ☐ Washingtonian/other magazines ☐ Dental Society ☐ Internet ☐ other: _____

Name of person or office referring you to our practice: _____

Consent for Services/Office Policy

I hereby consent to services to be performed by Dr. Christopher, Dr. Favagehi and their staff.
Radiographs (x-rays), photographs, 3D scans, videos, and study models maybe produced as a diagnostic aid or document my condition or for communications with other doctors, dentists, labs and for teaching. In any case, my privacy, identity and any identifiable photos will be safeguarded for privacy and will not be disclosed. I understand dental treatment may at times cause adverse effects such as sensitivity, and in rare situations, it may result in temporary or permanent damage to teeth, including adjacent teeth, or restorations/facial structures and/or numbness or other injury. I understand that to ensure long-term success, regular maintenance /dental checkups are necessary.

I understand that I am fully responsible for payment for services to be rendered at the time the service is initiated. I agree to pay for my dental treatment. Financial arrangement, such as financing and insurance or 3rd party payer arrangements must be made in advance. **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, I understand that I am responsible for payments, and I shall not seek services on the assumption that charges will be paid by an insurance company. I understand that insurance companies may or may not reimburse for services provided by Drs. Christopher & Favagehi.**

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.
I further agree in the event of non-payment, to bear the cost of collections and/or court cost and reasonable legal fees should be required.

I grant my permission to Drs. Christopher & Favagehi and their staff, to contact me by phone, text message or e-mail if necessary.
I have been informed that this office follows the regulations of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for the Protection of patient privacy & security of personal information.

APPOINTMENT POLICY: Broken or missed appointments

I understand that a 48- hour notice (2 working days) must be given for the cancellation of any appointment, and failure to do so will result in a "broken appointment" fee charged to my account based on the following fee schedule:
1st missed appointment fee: $50.00
1st missed surgical appointment fee: $150.00
2nd missed (broken appointment): $ 250.00 and it may result in dismissal from the practice as a patient.
I understand that insurance does not cover any of the "broken appointment" fees based on the above fee schedule. I also understand that the broken appointment fee will apply no matter what reason or excuse given by me for the broken appointment.
Late arrivals (over 30minutes) may be charged for broken appointments and/or rescheduled for another day.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian