Roxanne Azmoudeh, DDS

44355 Premier Plaza, Suite 100
Ashburn, VA 20147
(703) 858-9146

Patient Information

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

Gender: _____ ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date: _____

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

E-mail Address:_____ May we contact you by e-mail ☐ Yes ☐ No

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

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

☐ AIDS
☐ Abnormal Bleeding Tendencies
☐ Codeine allergy
☐ Penicillin allergy
☐ Latex allergy
☐ Metals allergy
☐ Amoxicillin allergy
☐ Seasonal allergies
☐ Any other allergies?

_____
_____
_____

☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Blood Transfusions
☐ Breathing Difficulties
☐ Bronchitis

☐ Cancer
☐ Chronic Cough
☐ Chemotherapy
☐ Cirrhosis
☐ Colitis
☐ Coronary Artery Disease
☐ Drug addictions
☐ Diabetes
☐ Dizziness
☐ Earaches/ringing in ears
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Fever Blister/Cold Sores
☐ Gastritis
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head & Neck Radiation

☐ Head Injuries
☐ Hearing Loss
☐ Heart Attack
☐ Heart Murmur
☐ Heart & Valve defects
☐ Hepatitis
☐ High Blood Pressure
☐ HIV Positive
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Mental Disorders
☐ Nervous Disorders
☐ Psychiatric Care
☐ Nervous Disorders
☐ Oral Cancer/Tumor
☐ Pacemaker
☐ Prosthetic Heart
☐ Prosthetic Joint(s)
☐ **Pregnancy** Due date:_____
☐ Psychiatric Treatment

☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sever Headaches
☐ Sexually Transmitted Disease
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Urinate frequently
☐ Venereal Disease

OTHER:
☐ _____
☐ _____

- 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 Date of last complete exam?_____
  If yes, please explain: _____
- Name of Physician: _____ Phone#: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever taken Phen-Fen or Redux? ☐ Yes ☐ No
- Are you taking any medications at this time? ☐ Yes ☐ No

Medication	**Dosage**	**How Often**	**How Long**

Patient Name: _____ **Date:** _____

Do you smoke? ☐ Yes ☐ No ☐ I used to but I quit Do/ Did you chew tobacco? ☐ Yes ☐ No
If yes, how much?_____How Long?___

Have you ever had an allergic reaction to medication/anesthetic? ☐ Yes ☐ No
If yes, what medication(s)_____
What kind of reaction did you have?_____

- Do you have a history of illegal drug or alcohol abuse? ☐ Yes ☐ No If yes, what did you use? _____

- Do you grind/clench your teeth during the day or night? ☐ Yes ☐ No

- Are you interested in teeth whitening? ☐ Yes ☐ No

- Are you interested in orthodontic therapy (braces or Invisalign)? ☐ Yes ☐ No

Name of your previous Dentist:_____

- Have you ever had any serious trouble associated with dental treatment/surgery/extraction? ☐ Yes ☐ No
If yes please explain?_____

- Have you ever had any complications following dental treatment?
If yes, please explain: _____

- Have you ever had an unusual reaction to dental anesthetic? ☐ Yes ☐ No
If yes please explain _____

Nearest relative to contact in case of emergency:_____ Relationship_____Phone_____

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 (if the patient is under 18 years of age)

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend (Name) :_____

☐ Yelp ☐ Insurance Company ☐ Office Website ☐ Other _____

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

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for the patient, or parent, if patient is under 18 years old:

Employer's Name: _____ Occupation: _____

Address: _____ _____
Street City, State zip Code Phone

Patient Name: _____ **Date:** _____

Insurance Information

Primary Insurance Name: _____ Subscriber ID#: _____ Group #: _____

Policy Holder's Name (Main subscriber): _____ SSN: _____
First Name MI Last Name

Policy Holder's Birthdate: : _____ Insured's Employer's Name: _____

Insurance Company Address: _____
Street City State Zip Code

Policy Holder's relationship to the Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

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 of services performed.

We reserve the right to charge $50 per half hour for broken appointments without 48 hours advanced notice, and there will be a charge of $30 for any returned or dishonored checks.

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.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

_____ Date: _____ Relationship to Patient: _____
Printed name of patient, parent or guardian (If patient is under 18)

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

Insurance Consent

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims.

I hereby authorize the direct payment of the dental benefits otherwise payable to me, directly to Dr. Roxanne Azmoudeh

X_____
Signature of Responsible Party/Parent or Guardian

Patient Name:_____ **Date:**_____

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

Roxanne Azmoudeh, DDS
44345 Premier Plaza
Suite 100
Ashburn, VA 20147
703-858-9146

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)