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: ___________________________________

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Allergies: ____

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