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
___ Bleeding gums
___ Clicking or popping jaw
___ Food collection between teeth
___ Grinding teeth
___ Loose teeth or broken fillings
___ Periodontal treatment
___ Sensitivity to cold
___ Sensitivity to hot
___ Sensitivity to sweets
___ Sensitivity when biting
___ 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
___ Arthritis, Rheumatism
___ Artificial Heart Valves
___ Artificial Joints, Pins, etc.
___ Asthma
___ Back Problems
___ Bleeding Abnormally
___ Blood Disease
___ Cancer
___ Chemical Dependency
___ Chemotherapy/ Radiation
___ Circulatory Problems
___ Head Injuries
___ Congenital Heart Lesions
___ Cortisone Treatments
___ Cough, Persistent
___ Cough up Blood
___ Diabetes
___ Epilepsy/Seizures/ Fainting
___ High Blood Pressure
___ Glaucoma
___ Headaches
___ Heart Murmur
___ Heart Problems
___ Hemophilia
___ Mental Disorders
___ Hepatitis
___ Hernia Repair
___ HIV/AIDS
___ Jaw Pain
___ Kidney Disease
___ Liver Disease
___ Mitral Valve Prolapse
___ Pacemaker
___ Jaundice
___ Respiratory Disease
___ Rheumatic Fever
___ Scarlet Fever
___ Shortness of Breath
___ Skin Rash
___ Stroke
___ Swelling of Feet/Ankles
___ Thyroid Problems
___ Tobacco Habit
___ Tonsillitis
___ Tuberculosis
___ Ulcer
___ Venereal Disease
___ Sinus Problems

List medications you are currently taking and correlating diagnosis: _____
_____

Allergies: _____

Notes:
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