Zadeh Family& Implant Dentistry
611 South Carlin Springs Rd Suite 206
Arlington, Virginia 22204

Patient Information:

Patient's Name: _____ DOB: _____ SS#_____

Address: _____ Apartment#: _____

City: _____ State: _____ Zip Code: _____

Home# (_____)_____ Work# (_____)_____ Ext_____ Cell# (_____)_____

Age: _____ Gender: M ( ) F( ) Marital Status: Single ( ) Married: ( ) Divorced: ( ) Widowed: ( )

Email Address: _____

Employer: _____ Occupation: _____

Employers Address: _____ City _____ State _____ Zip Code _____

In case of an emergency contact:

Name: _____ Relationship_____ Phone #: _____

How did you hear about us? : _____

Dental Insurance Information:

Who is responsible for this account? _____ Relationship to patient: _____

Subscriber's Name: _____ ID#: _____ DOB: _____

Insurance Name: _____ Group# _____ Family Plan? _____

Assignment and Release

I, the undersigned certified that I (or my dependent) have insurance coverage with _____
And assign directly to Dr. David Zadeh D.D.S all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission. I understand that payment is expected when services are rendering.

_____ _____

Responsible Party Signature **Date**

Please continue over

Health History

Physicians Name: _____Phone# ( ) _____ Date of last visit _____

Are you under the care of a physician? Yes ( ) No ( )

If so, what is the condition being treated? _____

Does your physician requires to take any medication before having dental treatment Yes ( ) No ( )

If so, please specify _____

Please mark "Yes" or "No" to indicate if you have any of the following:

1) AIDS/HIV	**YES**	**NO**	**25) Herpes**	**YES**	**NO**
2) Anemia	**YES**	**NO**	**26) High Blood Pressure**	**YES**	**NO**
3) Arthritis, Rheumatism	**YES**	**NO**	**27) Jaundice**	**YES**	**NO**
4) Arthritis Heat Valves	**YES**	**NO**	**28) Jaw Pain**	**YES**	**NO**
5) Artificial Joint	**YES**	**NO**	**29) Kidney Disease**	**YES**	**NO**
6) Asthma	**YES**	**NO**	**30) Liver Disease**	**YES**	**NO**
7) Back problems	**YES**	**NO**	**31) Low Blood Pressure**	**YES**	**NO**
8) Abnormal bleeding with extractions	**YES**	**NO**	**32) Respiratory Disease**	**YES**	**NO**
9) Blood Disease	**YES**	**NO**	**33) Rheumatic Fever**	**YES**	**NO**
10) Cancer	**YES**	**NO**	**34) Scarlet Fever**	**YES**	**NO**
11) Chemical Dependency	**YES**	**NO**	**35) Shortness of breath**	**YES**	**NO**
12) Chemotherapy	**YES**	**NO**	**36) Sinus Trouble**	**YES**	**NO**
13) Circulatory Problems	**YES**	**NO**	**37) Skin Rash**	**YES**	**NO**
14) Congenital Heart Lesions	**YES**	**NO**	**38) Stroke**	**YES**	**NO**
15) Cortisone Treatment	**YES**	**NO**	**39) Thyroid Problems**	**YES**	**NO**
16) Diabetes	**YES**	**NO**	**40) Venereal Disease**	**YES**	**NO**
17) Emphysema	**YES**	**NO**	**41) Ulcer**	**YES**	**NO**
18) Epilepsy	**YES**	**NO**	**42) Tuberculosis**	**YES**	**NO**
19) Fainting or Dizziness	**YES**	**NO**	**43) Swollen neck Glands**	**YES**	**NO**
20) Glaucoma	**YES**	**NO**	**44) Weight Loss**	**YES**	**NO**
21) Headaches	**YES**	**NO**	**45) Tumor or Growth on head or neck**	**YES**	**NO**
22) Heart Murmur	**YES**	**NO**	**46) Pacemaker**	**YES**	**NO**
23) Heart Problem	**YES**	**NO**	**47) Other? _____**		
24) Hepatitis Type	**YES**	**NO**			

Women:

Are you Pregnant? Yes ( ) No( ) Due Date: _____ Are you Nursing? Yes ( ) No( )
Are you taking birth control pills? Yes ( ) No ( )

Allergies:

( ) Aspirin Sulfa ( ) None ( )
( ) Codeine Penicillin ( ) Other: _____
( ) Local Anesthetic Latex ( ) List any medications you are currently taking _____

Dental History

1) Bad Breath:	**YES**	**NO**	**11) Jaw pain or tiredness**	**YES**	**NO**
2) Bleeding Gums:	**YES**	**NO**	**12) Fingernail biting**	**YES**	**NO**
3) Blisters on lips or mouth:	**YES**	**NO**	**13) Food collection between the teeth**	**YES**	**NO**
4) Burning sensation on tongue:	**YES**	**NO**	**14) Pipe or Cigarette smoking**	**YES**	**NO**
5) Clicking or popping jaw:	**YES**	**NO**	**15) Grinding teeth**	**YES**	**NO**
6) Dry Mouth:	**YES**	**NO**	**16) Periodontal treatment**	**YES**	**NO**
7) Swollen Gum:	**YES**	**NO**	**17) Lip or Cheek biting**	**YES**	**NO**
8) Sensitivity to cold or hot	**YES**	**NO**			
9) Loose teeth or broken teeth	**YES**	**NO**	**18) How often do you floss? _____**		
10) Sensitivity to sweets	**YES**	**NO**	**19) How often you brush? _____**		

Dr. David Zadeh D.D.S
611 South Carlin Springs Rd, Suite 206 Arlington, Virginia 22204

Office Policy

OSHA: With the advance of the Federal Regulations regarding the sterilization procedures and Infection Control used in dental offices and the public concern regarding communicable disease this office has adopted the policy of charging a fee for OSHA compliance. We are not passing through the entire cost of sterilization but sharing it with you. The fee will be charged every time a patient sits in the operatory. The OSHA fee is not covered by many dental Plans or insurance companies. We hope you understand and appreciate our attention to your growing concern for safety.

Emergencies: We try our best to provide emergency care to all those patients in need. Please call us early in the day and be flexible with your time so that we can treat your problem promptly. As we do see emergencies, please understand that this can cause the doctor to run behind on his regular appointment schedule. We strive to be on time and hope that you will be patient and understand if we do run late at one time or another.

Treatment Estimate: We try to estimate your treatment prior to performing the services that you need so that all patients are aware of the financial requirements. If you have any questions please ask them so that you clearly understand the treatment you will be receiving and financial responsibilities.

(Initial**)_____ Dental Insurance**: Please feel free to ask any question regarding your insurance. We will try to provide you with all the information we obtain from your insurance provider. The agreement is between you and the insurance company, and you are responsible for all charges not covered by your insurance.

Dental Records: To obtain copies of your medical records, you must sign a Dental Release Form. Please allow one to two weeks for processing.

Consent: The undersigned hereby authorize the Doctor to take x-ray, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.
I understand that my dental insurance in contracted between the insurance carrier, and me and not between the insurance carrier and the doctor and that I am still fully responsible for all dental fees. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credit to my account.

I fully understand the office policy presented to me and agree to abide by the guideline set forth above.

_____ _____

Signature of Patient Or Parent if Patient is a minor Date

Written Financial Policy

Thank you for choosing Zadeh Dental office. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, check, Visa, MasterCard or American Express
We offer a 3% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card prior to completion of care for treatment plans of $500.00 or more.

- NO INTEREST Payments Plans from the Care Credit

- Allow you to pay over time with NO INTEREST
- Convenient, low monthly payment plans also available
- No annual fees or pre-payment penalties

Please note:

Zadeh Dental Office requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

We accept payment in thirds for treatment over $900.00. For plans requiring more than 3 appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $1500 or more, a 1/3 deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $50 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.
Multiply missed appointments may result in your dismissal as a patient.

Zadeh dental Office charges $50 for returned checks.

We honor our senior citizens with a 3% discount.

Dental Records: To obtain copies of your medical records, you must sign a Dental Release Form. Please allow one to two weeks for processing records

Signature of Patient or Guardian Signature Date

Patient name (Please Print)