Herndon Family and Cosmetic Dentistry
104 Elden Street, Suite 16A Herndon VA, 20170 Phone: 703-787-7778 Fax: 571-203-1390

PATIENT REGISTRATION

Today's Date: _____ /_____ / _______ Birth Date: ____ /_____ / _____

Name: ____S.S.N.__________________

First Name Last Name MI Preferred Name

Home Address: ________________________________ City: ____________ State: _____ Zip: ______

Work Address: _________________________________City: ____________ State: _____ Zip: ______

Home #: _____________________ Work #: ___________________ Cell #: ______________________

E-Mail: ____

Are you: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced

Spouse or Parent's Name:____

Employed by: ________________________ Occupation: _____________________

Referred to our office by: _________________________

Dental Insurance: ____

Name Policy Holder Name & SSN Group#

Emergency Contact: ____

Name Address Home Phone Work Phone

Physician: ____

RESPONSIBLE PARTY

Name of person responsible for this account: ____

Relationship to patient: _____________________________________ Phone: ______________________________

Address: ______________________________ City: ____________________ State: _______ Zip: _____________

MEDICAL HISTORY

Describe your general medical health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently under the regular care of a physician? ☐ Yes ☐ No

Have you ever been hospitalized or had an operation? ☐ Yes ☐ No

Do you have any problems with anesthesia, General or Local? ☐ Yes ☐ No

Have you ever taken Recreational Drugs? ☐ Yes ☐ No

Have you ever taken Podimin, Redux or Fen-Phen? ☐ Yes ☐ No

Are you sensitive or allergic to any medications? ☐ Yes ☐ No

☐ Penicillin ☐ Aspirin ☐ Local anesthetic ☐ Codeine ☐ Latex______________
☐ Motrin/Ibuprofen ☐ Other______________

Have you ever had skin reaction to metals in jewelry? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If Yes, How Much?

Women: Do you take oral contraceptives? ☐ Yes ☐ No

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Check any of the following which you currently have, or have had

☐ Heart Disease	☐ Tuberculosis	☐ Kidney Disease	☐ Stroke
☐ Heart Lesions	☐ Asthma	☐ Liver Disease	☐ Arthritis
☐ Cardiac Pacemaker	☐ Diabetes	☐ Hepatitis/Jaundice	☐ Psychiatric Care
☐ Heart Murmur	☐ Radiation Treatment	☐ Epilepsy	☐ Rheumatic Fever
☐ Mitral Valve Prolapsed	☐ Cancer	☐ Anemia	☐ Ulcers
☐ High Blood Pressure	☐ Sinus Trouble	☐ AIDS/ARC/HIV Positive	☐ Tumors

Have you had any other serious illness? ☐ Yes ☐ No

Please list the name of all your current Medications:

____

____

____

Doctor's Signature________________________ Date_______________________

DENTAL HISTORY

When was your last dental visit? ____________ What was done? __________________

How would you describe your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have a problem with any of the following?

☐ Teeth sensitive to hot
☐ Teeth sensitive to cold
☐ Teeth sensitive to sweets
☐ Teeth sensitive to chewing
☐ Receding gums
☐ Sore Gums
☐ Bleeding gums
☐ Frequent cold sores/ canker sores

Do you grind/clench your teeth? ☐ No ☐ Yes, but I don't think it's causing any problems
☐ Yes, and I think it may be causing Problems

Do you feel like you still get a lot of cavities? ☐ No ☐ Yes, but I probably wouldn't do home care
☐ Yes, and I may consider home care

Do you frequently get bad breath? ☐ No ☐ Yes, but I can usually fix it myself
☐ Yes, and I would like to discuss treatments

Check any of the following that you have had:

☐ Orthodontic Treatment
☐ TMJ Treatment
☐ Gum Treatment
☐ Root Canals
☐ Wisdom teeth removed
☐ Bridges/Partials

Is there any old dentistry you want replaced? ☐ Yes ☐ No

How well do you clean your teeth and gums? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How often do you Brush? ________ Floss? ___________

Do your gums bleed? ☐ Never ☐ Occasionally ☐ Frequently
☐ Every time I brush ☐ Only when I floss

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What phrase best describes how you feel about losing your teeth?

- ☐ It doesn't bother me
- ☐ I thought everyone did eventually
- ☐ I'll do my best to prevent it
- ☐ I'd do anything to save my teeth

How do you rate your smile on a 1-10 scale?

Unhappy 1 2 3 4 5 6 7 8 9 10 Very Happy

What best describes how you feel about your smile?

- ☐ Satisfied
- ☐ If it could be improved easily and inexpensively, I might consider
- ☐ I'd do anything to improve my smile

If looking for some improvement, is it for:

☐ Color ☐ Chips ☐ Spaces ☐ Crooked teeth ☐ Shape/ size
☐ Other______________________________________

In general, how do you view dental treatment?

- ☐ I'm fairly relaxed about it
- ☐ It makes me a little uneasy
- ☐ It makes me tense
- ☐ It makes me very anxious

Anything else we should know about? ____

What dental services are you expecting at today's visit? ____

FINANCIAL AGREEMENT

As the patient (or legal guardian), I verify that the responses listed above are true and complete, and authorize Dr. Elham Safari and staff to perform professional dental services.
I understand and agree that the payment of my bill is my obligation. All filings of insurance papers and confirmation of eligibility of benefits and/or confirmation of insurance payments to be made by any insurance company 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 of filing, follow-through or confirmations. I understand that all insurance co-payments are collected in advance and Treatment Plans are only estimates of treatment and cost. The insurance company makes the final determination of payment when they process the claim.
In the case that my account should become delinquent and is placed in the hands of an attorney for collections, I agree to pay attorney fees of 35 percent of the principal and interest balance owing, plus all courts cost, late charges, and finance charges at the rate of 1.5% per month (18% per annum) to any balance owed 60 days after services are rendered. I further agree to pay returned check charges of $25 per returned check.

Cancellations and Missed Appointments

Broken appointments are not fair to any parties involved. They deny other patients the use of time they cost the practice money as staff salaries and other expenses continue. They make our office hesitant to appoint that patient again. Our practice does not profit from these charges. We merely cover expenses incurred by broken appointments, we charge $45 per half an hour.

These charges are assessed to patients that have not given our office **48 hours** "business day" notice. By your signature, it is understood and agreed that you are directly responsible for the payment.

Patient Name ______________________________

Patient or Responsible Party Signature _______________________________ Date________________