

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
Address: _____
Street Apartment #
City State Zip Code

Health Information

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

Has your child ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

- Has your child ever had complications following dental treatment? Yes No
If yes, please explain: _____
- Has your child ever been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Is your child under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Does your child have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child has a change of health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages internet School Magazine 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: _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street

City

State

Zip Code

Phone

Insurance Information

Primary

Name of Insured: _____

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: _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____

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: _____

Insurance Plan Name and Address: _____

Consent for Services

- 1) The undersigned hereby authorizes doctor or staff to take x-rays, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
- 2) I authorize the doctor to perform all recommended treatment mutually agreed up by me and to use appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- 3) I understand that all responsibility for payment for dental services approved in this office is due and payable at the time of services are rendered unless other arrangements are made.
- 4) I understand that if bill is past due, collection charges may be incurred to my account.
- 5) I understand that there will be a charge of \$85 for failed appointments or cancellations without 48 hours notice if the office deems necessary.
- 6) I understand that claims are sent out as a service, but if insurance does not pay what was thought, it is the patient's responsibility.

- 7) I authorize this office to obtain any medical information about my child. I understand that this information will be kept in absolute confidence.
- 8) I hereby authorize payment of the dental benefits otherwise payable to Neda Kalantar, DDS, PLLC
- 9) I have been shown a copy of Neda Kalantar, DDS, PLLC. Pediatric Dentistry of Reston's notice of Privacy Practices and understand I can request a copy.
- 10) I give consent to use and disclose my child's protected health information to carry out treatment, payment activities and health care operations.
- 11) 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: _____

Signature of parent or guardian

