Raman Jassal, DDS, INC & Associates
HERNDON FAMILY DENTAL
703-787-9000
MEDICAL-DENTAL HISTORY

NAME OF PATIENT: _____

PLEASE ANSWER EACH QUESTION BY SELECTING **YES OR NO:**

1. Have you been a patient in a hospital during the past 2 years? **YES** **NO**
   FOR: _____
2. Have you been under the care of a physician during the past 2 years? **YES** **NO**
   FOR: _____
3. Have you taken any kind of medicine or drugs during the past 2 years? **YES** **NO**
   Name of Drug: _____
4. Have you ever experienced an unusual reaction to any of the following drugs: **YES** **NO**
   ** aspirin, penicillin, iodine, codeine or other narcotics or any medicine?

Name of Drug: _____

5. Have you ever had any excessive bleeding requiring special treatment: **YES** **NO**
6. Circle any of the following below, which you have had or currently have:

AIDS or HIV positive	Artificial heart valves	Congenital heart lesions	Heart murmur
Anemia	High blood pressure	Low Blood Pressure	Heart trouble
Asthma	Kidney treatment	Rheumatic fever	Jaundice
Cold sores	Hepatitis	Psychiatric treatment	Glaucoma
Stroke	Diabetes	Cardiac pacemaker	Tuberculosis
Persistent cough	Cancer treatment	Epilepsy	Sinus trouble
Allergies	Venereal disease	Arthritis	Stomach ulcers
Immune system disorders	Respiratory problems	Rheumatic heart disease	Thyroid problems
			Sleep disorders

7. Have you had any other serious illness or accident? **YES** **NO**
   List the illness or accident with year: _____
8. If female, are you pregnant now? **YES** **NO**
9. Have you had any serious trouble associated with any previous dental treatment? **YES** **NO**
   Explain: _____
10. Do you currently smoke or partake of tobacco products of any kind? **YES** **NO**

DENTAL RESPONSES:

11. Are you happy with your smile? **YES** **NO**
12. Do you gums bleed sometimes? **YES** **NO**
13. Are your teeth painful? **YES** **NO**
14. Can you chew well on both sides of your mouth? **YES** **NO**
15. Are you wearing removable dental appliance? **YES** **NO**

LIST main dental complaint(s): _____

I certify that I have read and understand the above. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ **Patient's / Guardian's Signature: _____**

Date: _____ **Reviewed By: _____**

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PATIENT INFORMATION

Name_____ Date of Birth ____ / ____ / ____Age ____

Address _____ City _____ Zip _____Sex ____

(H) Phone #_____ (W) Phone #_____ (cell) phone #_____

Soc. Sec. # _____ - ____ - _____ Fax # _____

Occupation _____ Employer _____

Address of Employer _____

Martial Status Married Single Widowed Divorced

Referred by_____ e-mail address_____

Spouse / Parent Information

Spouse/Parent Name_____ Date of Birth ____ / ____ / ____

Soc. Sec. # _____ - ____ - _____ Occupation _____ Employer_____

Address of Employer_____

(H) Phone #_____ (W) Phone #_____ (cell) phone #_____

Insurance Information

Name of Ins._____ Policy #_____

Address of Ins._____ Zip _____

Group #_____

Subscriber_____ Phone # of Ins. _____

Relationship to Patient Self Child Spouse Parent Guardian Other

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PATIENT AUTHORIZATION

I, _____, hereby authorize Raman K. Jassal, D.D.S. and associates to render dental treatment services as required and apply for benefits on my behalf for these covered services rendered by this office, and request that payments are made directly to the dentist. I certify that the information reported is correct and further authorize the release of records, including X-rays, necessary to secure payment. A photocopy is to be considered valid and original.

I also understand that I am financially responsible for all charges, whether or not paid by the said insurance, incurred by myself, my spouse and/or dependents. There is a $37.00 check return fee. I agree that in the event my account should become past due and is turned over to third party for collection, I will also be liable for any and all costs incidental thereto, including attorney's fees, in the amount of 1/3 of the principal balance, plus all court costs and interest of 1.5% per month (18% annually). I also acknowledge that I received and/or reviewed the Office Privacy Policy Notice (OPPN), which is posted near the left side of the dental operatory room. Copies of the OPPN are available upon request.

Date: _____ **Patient's / Guardian's Signature: _____**

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FINANCIAL POLICY AGREEMENT

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. As part of our service, we try to contain the ever-rising cost of health care. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE WE ACCEPT CASH, CHECKS, VISA/MASTERCARD/DISCOVER, OR DEBIT CARDS

REGARDING INSURANCE

DENTAL INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY. IT HAS NO CONNECTION, AT ALL, TO THE PROVIDER OF DENTAL TREATMENT. The extent of coverage varies greatly from company to company and sometimes even within a company. It has absolutely nothing to do with the level of service provided by the dentist and fee charged for these services.

We may accept assignment of insurance benefits (may not apply to emergency patients). We will make every effort possible to assist you with your particular coverage. Although it is not required, we will prepare and submit your insurance claim form at no cost as a courtesy to our patients. We will also provide an estimate that will show expected insurance reimbursement and patient share for every procedure. An estimate is calculated by adding 10% extra to whatever insurance company says they will pay. THE PATIENT SHARE, WHICH INCLUDES YOUR DEDUCTIBLE, WILL BE DUE AT TIME OF TREATMENT. Should our estimate of patient share be too high, a refund will be made at the time of payment from the insurance company. Likewise, if the estimate was low, the remainder will be due at that time. Should no insurance payment be made, or there is a balance, within sixty days after the original claim was submitted, the fee will be the sole responsibility of the patient or the responsible party.

In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account for the balance or be pre-approved on our extended payment plan.

USUAL AND CUSTOMARY RATES: An often-misunderstood term used by many insurance companies is "UCR". This is an arbitrary fee ceiling at which the insurance company will stop reimbursement. After this ceiling, coverage for a particular procedure will cease. Again, this has nothing to do with the fee charged, but with the level of coverage negotiated by your employer. YOU ARE RESPONSIBLE FOR PAYMENT REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES.

MINOR PATIENTS: The adult accompanying a minor and the parents (or the guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard/Discover, or payment by cash or check of service that has been verified.

I also agree that any dispute about the reasonableness or computation of fees, or any claim of negligent or intentional acts or omissions in the rendering of professional services for any treatment rendered by doctors or staff (including independent contractors) in this office, shall be submitted to binding arbitration. It is understood by both doctor and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other, arising out of this agreement, all disputes shall be resolved through arbitration and that patient and doctors have given up their right to a jury or a court trial.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to the Financial Policy:

Date:_____ **Patient/Guardian Signature:** _____

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NOTICE OF OFFICE POLICY

Thank you for choosing our office to meet your treatment needs. You are our valued patient and so to help us serve you better by noting the following policies:

- As a courtesy to patients before and after your appointment, we request that you arrive on time.
- If your insurance policy, address, or phone numbers have changed since your last visit, please come in 15 minutes early so we can make the necessary changes and see you on time.
- If for some unavoidable reason you are running late please let us know as soon as possible. In some instances, your appointment may have to be rescheduled.
- An appointment is considered confirmed at the time it is made. As a courtesy, we call to remind you two working days prior to your appointment between 9:00 AM and 1:00 PM. Please let us know the best phone number to reach you at this time.
- Your appointment time is reserved for you. If you are unable to keep it please give us 24 hours advance notice.
- Canceling / rescheduling without 24 hours notice or not showing up on the same day as your appointment will make you responsible for a $43.00 broken appointment fee for the first hour and $39.00 for each additional hour.
- We require a zero balance and a minimum of two working days to process any requests for copies of records. Nominal fee may apply.
- Replacement of lost or misplaced x-rays given to the patient will be at patient's expense.
- I also agree that any dispute about any claim of negligent or intentional acts or omissions in the rendering of professional services for any treatment rendered by doctors or staff (including independent contractors) in this office, shall be submitted to binding arbitration. It is understood by both doctor and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other, arising out of this agreement, all disputes shall be resolved through arbitration and that patient and doctors have given up their right to a jury or a court trial.

Please feel free to call us during business hours with any requests, questions, or updated information. Thank you.

Date: _____ **Patient's/Guardian's Signature**: _____