OFFICE USE

PATIENT # ______________

Fredericksburg Implant & Oral Surgery Associates

Patient Information

1. Name ____
2. Birth date __________________________ Sex _________ Marital Status _______________
3. Social Security # ____
4. Address ____

   ____

   City_____________________________ State__________ Zip ________________
4. Home Phone ( ) _______________________Work Phone ( ) _____________________
5. Cell Phone ( ) ____________________________
6. Employer Name____
7. Employer Address ____
8. Relation to Guarantor____
9. Referred by: General Dentist: ____________________________________

   Specialist: ______________________________ Other: ___________________________

10. Date of first visit ____

If *patient is a minor or student, please complete the following*:

FATHER

1. Name_____________________________________
2. Social Security #_________________________
3. Address _________________________________

   ____

   City _________________________________

   State ___________ Zip Code___________
4. Home Phone ( ) _______________________
5. Work Phone ( ) _______________________
6. Employer Name __________________________
7. Employer Address _______________________

MOTHER

1. Name____
2. Social Security #_____________________________
3. Address _____________________________________

   ____

   City _____________________________________

   State _____________ Zip Code _______________
4. Home Phone ( ) ___________________________
5. Work Phone ( ) ___________________________
6. Employer Name ____________________________
7. Employer Address ___________________________

____

<u>In case of emergency</u>, please contact:

Name ____ Home Phone ( ) ______________________

Address ____ Work Phone ( ) ______________________

Insurance Type
(Please circle)
Medical Dental

Primary Insurance

1. Employer ____
   Insurance Company ______________________________________
2. Group # ____

Subscriber Information

3. Relationship of Patient_________________________________
4. Name ____
5. Address ____
6. City ___________________ State ________ Zip Code ____________
7. Phone ___________________
8. Birth date ________________
9. Subscriber # ______________

Insurance Company Address ______________________________

Insurance Company Phone ( ) ____________________________

I have reviewed the proposed treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

× ______________________________
Signed (Patient, or parent IF minor) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

× ______________________________
Signed (Insured Person) Date

Language for Consent/Acknowledgement

Use and Disclosure of Protected Health Information

I understand that Keyoumars Izadi, MD, DDS may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the practice and individuals involved in my care in the practice may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at (540) 371-4131.

I understand that I have the right to request that the practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the practice is not required to agree to a requested restriction. However, if the practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the practice, or individuals involved in my care in the practice, have already used or disclosed protected health information in reliance on my prior consent.

× ______________________________ ____________ ______________________
Patient or Legal Surrogate Date Relationship to Patient

______________________________ ____________
Witness Date

Health Questionnaire
Fredericksburg Implant & Oral Surgery Associates

Patient Name:___________________________Birth Date:____________Chart Number:____________

Age: _____________ **Sex:** _____________ **Height:** _____________ **Weight:** _____________

PLEASE ANSWER ALL QUESTIONS AND FILL IN BLANK SPACES WHERE INDICATED. ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

1. Have you had food or drink today? Yes No
2. Are you in good health? Yes No
3. Your last physical examination was on ______________
4. Are you now under the care of a physician? Yes No
   If so, what is the condition being treated?
   ____
5. Name and Telephone Number of Physician ___________
   ____
   ____
6. Have you had any serious illness, operation, or been hospitalized? Yes No
   If yes, what was the problem and when?_____________
   ____
7. Do you drink alcoholic beverages? Yes No
8. Please answer yes or not to all items below. Have you had any of the following illnesses?

	Yes	No
AIDS	_____	_____
Allergies	_____	_____
Anemia	_____	_____
Angina	_____	_____
Arthritis	_____	_____
Artificial Joint Replacement	_____	_____
Asthma	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Emphysema	_____	_____
Epilepsy	_____	_____
Fainting	_____	_____
Glaucoma	_____	_____
Heart Attack	_____	_____
Heart Bypass	_____	_____
Heart Problem	_____	_____
Hepatitis	_____	_____
High Blood Pressure	_____	_____
HIV Positive	_____	_____
Kidney Disease	_____	_____
Liver Problem	_____	_____
Low Blood Pressure	_____	_____
Lung Disease	_____	_____
Rheumatic Fever	_____	_____
Stroke	_____	_____
Thyroid	_____	_____
Tuberculosis	_____	_____
Venereal Disease	_____	_____

Other:____
____

9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No
   A. Do you bruise easily? Yes No
   B. Have you ever required a blood transfusion? Yes No
   If "yes" explain circumstances________________________
   ____
10. Do you have any blood disorder such as anemia? Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition in you mouth or lips? Yes No
12. Are you taking any drug or medicine? Yes No
    If "yes" what medication ____________________________
13. Are you taking any of the following?
    A. Antibiotics or sulfa drugs Yes No
    B. Anticoagulants (blood thinner) Yes No
    C. Medicine for high blood pressure Yes No
    D. Cortisone (steroids) Yes No
    E. Tranquilizers Yes No
    F. Aspirin Yes No
    G. Insulin, Tolbutamid Yes No
    H. Digitalis or drugs for heart problems Yes No
    I. Nitroglycerin Yes No
    J. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, Aredia or Zometa for osteoporosis, or chemotherapy for multiple myeloma, etc.) ? Yes No
    K. Other____
14. Are you allergic or have you reacted adversely to:
    A. Iodine Yes No
    B. Local anesthetic Yes No
    C. Penicillin or other antibiotics Yes No
    D. Sulfa drugs Yes No
    E. Barbiturates, sedatives, sleeping pills Yes No
    F. Aspirin Yes No
    G. Other____
15. Have you had any adverse reaction associated with previous dental treatment? If so explain__________________________
    ____
16. Have you had any adverse reaction associated with previous medical treatment? If so explain________________________
    ____
17. Are you pregnant? Yes No

I have filled out this health questionnaire completely. I have advised you of all medial problems of which I am aware.

____

Patient Signature Date

I have reviewed the health history form above.

____

Doctor Signature Date

FINANCIAL CONTRACT

In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary.

The undersigned understands that Medical/Dental Insurance claims may be billed by the provider as a courtesy if the provider participates in the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the Federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I: ( ) am **an** active duty member of the U.S. Armed Forces
( ) **am not** an active duty member of the U.S. Armed Forces

DATE:_____________________ ____

Responsible Party