

Davoud Zadeh, D.D.S.
Family and Implant Dentistry

611 S. Carlin Springs Rd, #408
Arlington, Virginia 22204
(703) 671-7500

308 Dominion Road, NE
Vienna, Virginia 22180
(703) 242-9009

Patient Information

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

Address: _____ Apt#: _____

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, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Davoud Zadeh 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, and authorize the use of this signature on all insurance submissions. I also understand that payment is expected when services are rendered.

Responsible Party Signature

Date

Health History

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

Are you under the care of a physician? No () Yes () if so, name: _____

If so, what is the condition being treated? _____

Does your physician require you 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? _____ | | |

Davoud Zadeh, D.D.S.
Family and Implant Dentistry

611 S. Carlin Springs Rd, #408
Arlington, Virginia 22204
(703) 671-7500

308 Dominion Road, NE
Vienna, Virginia 22180
(703) 242-9009

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 diseases, this office has adopted the policy of charging a fee for OSHA compliance. We are not passing on 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 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 if we do occasionally run late.

Treatment Estimate: We try to estimate your treatment prior to performing services needed 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 any financial responsibilities.

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 patient hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patients' dental needs. In addition, the doctor is authorized to perform any and all forms of treatment, medication, and therapy that may be indicated, including the use of anesthetic agents which may embody certain risks. It is understood that dental insurance is contracted between the insurance company and the patient (not between the insurance company and the doctor) and that the patient is fully responsible for all dental fees. Your signature assigns all insurance payments to the doctor, to be credited to your account.

By signing below, you attest that you understand our office policy and agree to abide by the guidelines.

Signature of Patient or Responsible Party

Date

Davoud Zadeh, D.D.S.
Family and Implant Dentistry

611 S. Carlin Springs Rd, #408
Arlington, Virginia 22204
(703) 671-7500

308 Dominion Road, NE
Vienna, Virginia 22180
(703) 242-9009

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 treatment easy and manageable by offering several payment options.

Payment Options

You may choose to use:

- CASH*
- CHECK *
- VISA, MASTERCARD, AMERICAN EXPRESS*

**We offer a 5% discount when payment is made prior to completion of treatment.
(for treatment plans of \$300.00 or more)*

- CARE CREDIT

*Allows you to make convenient, low, monthly payments with NO INTEREST,
no annual fees, and no 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 minus the cost of care received.

We accept payments in thirds for treatment over \$600.00. For plans requiring more than 3 appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of \$1,500.00 or more, a 33% 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 benefits and directly bill them for reimbursement for your treatment.

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

Our office charges \$50 for returned checks. We honor our senior citizens with a 5% discount.

Signature of Patient or Responsible Party

Date

Patient name (Please Print)