TDG DENTAL GROUP, PLLC

3114 Golansky Blvd Ste #102
Woodbridge, VA 22192
(703) 583-2800

10630-B Crestwood Drive
Manassas, VA 20109
(703) 330-5578

We are in the process of updating your file and would like to verify the information we currently have.
Below you will find some common questions that we need to update our office records. The updated information will help us to update your personal file before you come up the office for your next dental appointment.

Patient Name: _____ DOB: _____

Home address: _____

City, State, Zip: _____

Primary Contact Phone #: _____ ☐Home ☐Cell ☐Work

Secondary Contact Phone #:_____ ☐Home ☐Cell ☐Work

Email address: _____

Responsible Party Name: _____ DOB: _____

Medical information Update:

Have you ever had any of the following? Please check those that apply:

☐ AIDS	☐ Fainting	☐ Liver Disease	
☐ Allergies _____	☐ Glaucoma	☐ Mental Disorders	☐ Tuberculosis
☐ Alcohol/Drug Abuse	☐ Growths	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Hay Fever	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Head Injuries	☐ Pregnancy	☐ Venereal Disease
☐ Artificial Joints	☐ Heart Attack	Due date:_____	OTHER:
☐ Asthma	☐ Heart Surgery	☐ Radiation Treatment	☐ _____
☐ Blood Disease	☐ Heart Disease	☐ Respiratory Problems	
☐ Cancer	☐ Heart Murmur	☐ Rheumatic Fever	☐ _____
☐ Diabetes	☐ Hepatitis	☐ Rheumatism	
☐ Dizziness	☐ High Blood Pressure	☐ Sinus Problems	
☐ Epilepsy	☐ Jaundice	☐ Stomach Problems	
☐ Excessive Bleeding	☐ Kidney Disease	☐ Stroke	

- Do you have any symptoms of sleep apnea? ☐ Yes ☐ No
  If yes, would you like to discuss dental solutions?: _____
- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list: _____
- Are you allergic to any medications? ☐ Yes ☐ No
  If yes, please list: _____
- Do you have any other health problems that need further clarification? ☐ Yes ☐ No
  If yes, please list: _____

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

Patient/ Responsible Party Signature: _____ Date: _____

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TDG DENTAL GROUP, PLLC
Office Policy

Insurance

As a courtesy to our valued patients, our office will directly bill the insurance company for all treatment. However, we do ask patients to be prepared to make any payment towards your treatment at the time the service is rendered. Our practice is committed to providing the best treatment for our patients and charges what is usual and customary for our area. Please understand that you are fully responsible for all treatment rendered which includes services payable by your insurance company as determined by your policy.

Discount Plans

Discount plans such as Carrington, Kaiser, and DentaQuest….etc. are dental plans which allow patients to receive dental services at a discount. In accordance with your contract, payment in full is required at the time that services are rendered.

Insurance Payments

Our office will make every attempt to collect from your insurance company. In the rare event that your insurance company does not pay within 60 days, the patient will be responsible for the balance in full which will be charged to patient directly. By signing below I authorize that any unpaid balance within 60 days from date of service that my insurance company has not paid for will be charged to me directly.

Type of Payments Accepted

- All major credit/debit cards
- Cash
- Checks
- Care Credit
- Flex accounts

Scheduling and Cancellations

Because we value the time spent with our patients, all appointments made are reserved solely for you and the doctor. Please give our office the consideration to fill your reservation if you need to cancel. Allow our office at least 48 hours advance notice for any cancellation. Any notice less than 48 business hours will be subject to a $30.00 broken appointment fee per half hour of appointment length.
Please Note: Saturday and Sunday do NOT constitute business days

Financial Agreement

To the best of my knowledge, the information provided to this office is complete and accurate. I acknowledge that all charges incurred in this office are my responsibility. Should my insurance for any reason, fail to pay for all charges billed, I agree to pay services upon notification by the office. I understand that if my account remains unpaid by me for a period of 90 days, my account may be sent to a collection agency. If my account becomes assigned to a collection agency, I agree to pay a 33% collection fee, interest in the amount of 18%, all court fees and all attorney fees as allowed by law.

Duplication of Records

In the event that your records need to be transferred for any reason other than the office referring you, there will be a charge of $25.00 for your records. We are required by law to keep your records on file for a period of 7 years.

By signing this form I acknowledge and agree to the terms and conditions of TDG Dental Group, PLLC Office Policy.

Patient Name: _____

Responsible Party: _____ Relationship to patient: _____

Patient or Responsible Party Signature: _____ Date: _____