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

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Primary Phone: _____ ☐Home ☐Cell ☐Work | Secondary Phone: _____ ☐Home ☐Cell ☐Work

Email Address: _____

Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

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

OTHER:

- ☐ _____
- ☐ _____

- 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: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you 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 I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or 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: _____ Is insured a patient? ☐ Yes ☐ No
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: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
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: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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 patient, parent or guardian

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: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____