SHINY DENTAL
6377 Little River Turnpike, Alexandria, VA 22312
Telephone # (703)- 333 - 5105 Fax: (703)-333 – 5106

PATIENT VISIT FORM

Name _____ _____ _____Title_____ SSN# _____
First Name Middle Last Name

Phone (_____) - _____ / Work (_____) - _____ Date of Birth: _____/_____/_____.
Month Date Year

Address _____Apt#_____ City _____Zip code_____

Email _____ Occupation _____Employer:_____

Emergency Contact Name _____ _____ _____Title_____
First Name Middle Last Name

Phone (_____) - _____ / Work (_____) - _____.

Address _____City _____Zip code____._____

Chief Complaint _____

Referred by_____ Phone (_____)_____-_____

Last Dental Visit Date _____/_____/_____Previous Dentist_____/_____
Name Phone

Are you Pregnant? **YES / NO** (for women only).

Medications you are taking_____

Are you under Physician care? **YES / NO** For what reason? _____

Mark **only** with symptoms you have:

____Teeth are sensitive to HOT, COLD, CHEWING ____Grinding or clenching ____ Bleeding Gum

____Excessive Bleeding ____Allergy to Local Anesthesia ____Allergy to Medication

____Heart Problems ____High Blood Pressure ____Asthma

____Rheumatic Fever ____Heart Murmur ____Mitral Valve Prolapsed

____Diabetes ____Epilepsy ____Hepatitis ____HIV positive

I, _____, understand that failing to provide an accurate condition of myself may effect to my treatment results. I authorize my Doctor perform this service.

X_____ Date _____
Patient's Signature or Patient's Guardian

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DENTAL INSURANCE/BENEFIT INFORMATION

Subscriber Name_____SSN#_____D.O.B.____/____/_____

Related to the patient: _____

Insurance Name _____Phone# _____

Group Name _____ Group # _____

Insurance Address: _____

ASSIGNMENT OF BENEFITS AND RELEASE INFORMATION

I authorize payment of dental benefits to myself or the name provider or professional services. I authorize the release of any necessary information to process this dental claim.

X_____ Date_____/_____/_____

Subscriber, Patient or Guardian

Payment Policy (PLEASE READ AND SIGN)

1. Emergency Services are expected to pay at the end of the visit
2. I Understand that I will be responsible for the Co-PAYMENT, DEDUCTIBLES and SERVICES which are NOT covered by my Dental Insurance/Benefits _____
3. If I break my appointment **without notices 24 hours in advance**, I will be charged up to **$25.00** for that half an hour appointment_____
4. After **60 days OVERDUE** Balances on my account will be added **5%** interest and will be sent for collection after 30 consequent days.

X_____ Date _____

Patient's Signature or Patient's Guardian

VERIFICATION OF DENTAL INSURANCES *(office only* #:_____Date: / / .

Maximum Benefits: $_____ Effective Date: ____/____/_____Waiting Periods?_____
Family Deductible: $_____ Single Deductible $_____

I. PREVENTATIVE: _____% Is Covered?

How many **CLEANINGS** *allowed per year? _____* **EXAMS?_____BWs_____PAN_____**
Any time or 6 months apart? _____. Is Fluoride covered?_____Up to_____
Up to what age the SEALANT is covered? _____ Which Teeth?_____,____,_____

II. BASIC: _____% Is Covered?

Are Peri-Apical or Bite-Wings Films included in Preventive or Basic?
Are Composite Fillings on posterior Teeth Covered? ___ Are ENDO &PERIO Covered in Basic or Major? ____

III. MAJOR: _____% Is Covered. **RCT? ____%, CROWN? _____% DENTURES? ____%**

Is There A Missing Tooth Clause? _____.

IV. PATIENT HISTORY:

When was the patient's last Prophy and Check Up? __/___/_____Was a PAN Film taken within last 3 Year?___
How much the maximum Benefits have been used? $_____