Maryam Avin, D.D.S.
19366 Diamond Lake Drive
Leesburg, VA 20176
703.687.3255

## Patient Information

Patient Name: _____ Birth Date:_____
Last First

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____Email Address: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Street Apartment # City Zip Code

**Employer Name**: _____ Occupation: _____

Whom may we thank for referring you to our practice? _____

## 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 _____
_____
☐Anemia
☐Arthritis
☐Artificial Joints
☐Asthma
☐Blood Disease
☐Cancer
☐Depression
☐Diabetes
☐Dizziness
☐Epilepsy
☐Excessive Bleeding
☐Fainting
☐Glaucoma
☐Growths
☐Hay Fever
☐Head Injuries
☐Heart Disease
☐Heart Murmur
☐Hepatitis
☐High Blood Pressure
☐HIV
☐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
☐Thyroid Problem
☐Tuberculosis
☐Tumors
☐Ulcers
☐Venereal Disease
☐Codeine Allergy
☐Penicillin Allergy
☐Latex Allergy
OTHER:
_____
_____

List medications Prescription & Non-Prescription : _____

_____

Do you have any problems related to snoring and TMJ? If yes, please explain:
_____
Are you now under the care of a physician? If yes, please explain:
_____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? Yes No If yes, explain:
_____

Have you ever had any complications following dental treatment? Yes No If yes, please explain:
_____

Emergency Contact: _____Phone: _____

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 the next appointment without fail.

X_____ Date: _____
**Signature of patient, parent, or guardian**

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## Responsible Party Information

☐ **Same as patient**

Name: _____ Social Security #: _____ Birth Date: _____
Last First

Phone - Home: _____ Work: _____ Other: _____

☐ **Same as patient address**

Address: _____
Street Apartment # City Zip Code

## Insurance Information

Subscriber Name: _____ Social Security #: _____ Birth Date: _____
Last First

## Financial Policy

Thank you for choosing our office for your dental care. We are committed to the success of your oral health.

*We ask that you realize that we don't work for insurance company, but we do work 100% for our patient.*
*Most insurance companies provide great benefits for our patients and we're going to do everything we can to maximize your benefits.*
*So please understand that the fees that we charge and the treatment that we're going to recommend*
*is specifically designed for your individual needs and never based on your insurance coverage.*

## Our Fees and Payment

Your co-payment and deductible are due at the time of service. To accommodate you we accept cash, check, Visa, MasterCard, Amex, Discover and CareCredit. For extensive treatment plans we offer flexible payment options however, arrangements must be set up prior to appointment. Any appointments one hour or longer will **require 1/3 deposit to reserve the appointment time**. All returned checks will be charged a fee of $45.00.

## Insurance Policy

On the day of your procedure your **full co-payment and deductible** are due. We will gladly submit the claims on your behalf; it is your responsibility to inform us of any changes to your insurance plan or benefits. We will try to assist you with your benefits, however knowing your benefits is your responsibility and all co-payments are an **estimate** of your benefits only. The estimate is never a guarantee of benefits or the amount that will be paid. If your insurance does **not** cover, denies, or does not make payment within 90 days the remaining balance is **your responsibility**. Due to the large volume of patients that we care for, we are unable to make frequent calls to your insurance carrier on your behalf.

## Missed and Cancelled Appointments

Please consider your calendar carefully when scheduling an appointment. We require **48** hours' notice to change or cancel your appointments. There may be a $100 fee per hour for all missed, cancelled, or changed appointments.

## Collection Accounts

Please note that if your account remains unpaid for a period of 30 days, interest at 1.5% will be applied per month and one time charge of **$45 for delay and unpaid balances**. If your account is sent to collections, you will be responsible for **all costs** involved with the collections process, which includes all court costs and attorney fees and finance charges. Your signature below indicates that you have read and agree to our financial policy. Thank you for being a valued patient.

X_____ Date: _____

**Signature of patient/ Responsible Party** **Name**

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## Your First Visit

Your initial first visit involves getting to know you, the problem you are experiencing and your dental needs. If you do not have any up-to-date copies of your dental records and X-Ray from your previous dentist; we will be taking full mouth X-Rays, photos and wellness scan to have an overview of your oral health. An overview of your mouth and gums will be followed by an oral cancer screening, then a thorough cleaning and polishing of your teeth. We will clean your teeth manually with traditional tools or use an advanced water powered instrument based on what is best for your specific needs. Fluoride treatments are recommended by the ADA for adults as well as children. After your initial appointment and reviewing your X-Rays, a treatment plan will be initiated this will give you an idea of what type of treatment you may need, the cost, and any insurance coverage.

**Initial:_____**

I authorize Avin Dental Care, to take photographs, and/or videos of my jaws and teeth ( No face), before, during and after treatment. I consent to allow the photographs or videos to be used for the following:

☐ Social media (Facebook, Instagram, Twitter, Google, Yelp) marketing material including websites and printed materials, patient education FULL MOUTH
☐ I refuse to share

## Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I authorize this information may be released to:

☐ Spouse ☐ Child(ren) ☐ Other ☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

X_____ Date: _____

**Signature of patient, parent, or guardian/ Responsible Party**

## Patient Screening Form

**Have you received your Covid-19 vaccination?** ☐Yes ☐No

Do you have fever/ cough/ shortness of breath? ☐ Yes ☐ No

Any other flu- like symptoms, such as gastrointestinal upset, headache, or fatigue? ☐ Yes ☐ No

Have you experience recent loss of taste or smell? ☐Yes ☐No

Have you traveled in the past 14 day? ☐Yes ☐No

Has anyone in your household has had any of these symptoms? ☐Yes ☐No