Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Home Phone (____)_____ Cell Phone (____)_____

Name _____ SS/HIC/Patient ID #_____
Last Name First Name Middle Initial

Address _____ E-mail_____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____)_____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initia

Relation to Patient _____ Birthdate _____ ID#/Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____)_____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (____)_____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone (____)_____

City _____ State _____ Zip _____

Subscriber Employed by_____ Business Phone (____)_____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Please Complete Both Sides

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mou

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (b names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ N

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ank
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

ALLERGIES

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign dire
Name of Insurance Company(ies)

Dr. Mandana GH-Zolghadr all insurance benefits, if any, otherwise payable to me for services rendered. I understa that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissio

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. T consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

The dental services rendered by the provider and the fees charged for these services are a contract between the dentist and the patient. The patient's share is always due at the time of treatment. Dental insurance is a contract between the insurer and the insured and the extent of coverage may vary from company to company and/or within a company. If insurance payment is not received within 45 (forty five) days of treatment, the fee becomes the sole responsibility of the patient.

I understand that;

- **The provider is not a guarantor of my insurance coverage and that I am financially responsible for all services rendered to me, including co-payment(s), and balance(s) on the day of service.**

- **Patient is responsible to know his dental plan benefits and his/hers maximum amount use on his/hers dental plan per calendar or contract year.**

- **Patient, who has two insurances, will be responsible to file claim(s) to a secondary insurance. Co-payments will be collected with primary insurance fee if the service is cover. If primary insurance does not cover the procedure, patient will be charge with office fees.**

- **If insurance denied the services, patient will be bill for the service.**

- **In the event that I fail to pay according to the terms stated in this agreement, the provider shall be entitled to commence collection action and/or legal action against me, giving me credit for any sums actually paid.**

- **Such action would increase the amount for which I will ultimately be responsible for in terms of associated collection fees, attorney's fees or court fees incurred.**

I acknowledge that I have read and understand this agreement and I agree to comply with its terms as stated.

Date: _____

_____
Patient's Signature

Mandana G.H. Zolghadr, D.D.S.

PLEASE COMPLETE BOTH SIDES

Dr. Mandana Zolghadr

Treatment Plan Policies

- Upon agreement of the patient's treatment plan, the charges for each procedure will be discussed with the patient and documented.
- Insurance co-pays/ deductibles will be paid on the day the services are rendered.
- Insurance coverage is ***estimated***- your actual coverage may be more or less. The patient is responsible for all amounts not covered by the insurance carrier.
- As a courtesy, crown and bridgework charges will be divided between the first and second visit. The second appointment must be within two weeks from when the final crown/ bridge is in.
- If a procedure such as a bleaching tray or appliances are requested by the patient, half the payment is due when the impressions are taken. The other half will be due upon delivery.

****

I understand and agree to all the above policies:

Patient Signature_____ Date: _____

Doctor Signature_____ Date: _____

PLEASE COMPLETE BOTH SIDES

Mandana Zolghadr, DDS

6082 Franconia Road Suite B, Alexandria, VA 22310
Phone: 703 719-0064
Fax: 703 719-9709

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Mandana Zolghadr, DDS, PC. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of the office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Mandana Zolghadr, DDS, PC reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Statement of Privacy Practices. I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.				
ANY MEMBER OF MY IMMEDIATE FAMILY		YES		NO
SPOUSE ONLY		YES		NO
OTHER (PLEASE SPECIFY):		YES		NO

Name if Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of acknowledgement not obtained					
PROVIDED PRIOR TO TREATMENT?		YES		NO	
DATE PROVIDED:					
REASON FOR DENIAL:		NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES			
		WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING			
		UNABLE TO SIGN			
		REASON NOT GIVEN			
		OTHER (EXPLAIN):			

INSURANCE COMPANIES WE PARTICIPATE WITH

AETNE

ALLIANCE DISC.5/ DISC.6

ANTHEM BC/BS / FEP BLUE

CAREFIRST BC/BS – FED 105-104

CIGNA

CONNECTION DENTAL

DELTA – DD OF CA/ VA/ PREMIER/ TRICARE

DENTE MAX

DENTEGRA

DENTAL BENEFIT PROVIDERS

DOMINION

GEHA DENTAL CONNECT

GUARDIAN

HUMANA

MAMSI – DISCOUNT FEE SCHEDULE/ DISC.5

MDIPA DISC.6

METLIFE

MUTUAL OF OMAHA

PRINCIPAL AMISTAS

SUN LIFE

UNITED CONCORDIA