M. Vajdi, DDS
908 New Hampshire Ave NW #100
Washington, DC 20037
202-822-3787
www.vajdidental.com

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

Name____Soc. Sec. #______________________
Last Name First Name Middle Inital
Address____
City_________________________State______Zip__________Home Phone________________
Cell Phone_____________________Email____
Sex ○ M ○ F Age____Birthdate_________ ○ Single ○ Married ○ Widowed ○ Separated ○ Divorced
Patient Employed by____________________________Occupation______________________
Business Address____
Business Phone_________________________________Business Email_________________
Whom may we thank for referring you?_______________________________________
Notify in case of emergency______________________________Home Phone______________
Business Phone_______________Cell Phone_______________Email___________________

Primary Insurance

Person Responsible for Account____
Last Name First Name Middle Inital
Relation to Patient____________________Birthdate_______________Soc. Sec. #______________
Address (if different from patient)____
City_________________________State______Zip__________Home Phone________________
Cell Phone_____________________Email____
Patient Employed by____________________________Occupation______________________
Business Address____
Business Phone_________________________________Business Email_________________
Insurance company______________________________Phone__________________________
Insurance Email____
Contact #___________________________Group #____________Subscriber #______________
Name (s) of other dependents under this plan_______________________________________

Additional Insurance

Is patient covered by additional insurance? ○ Yes ○ No
Subscriber's Name _____________________Relation to Patient____________Birthdate__________
Address (if different from patient)_______________________________Soc. Sec. #______________
City_________________________State______Zip__________Home Phone________________
Cell Phone_____________________Email____
Subscriber Employed by___________________________Occupation______________________
Business Phone_________________________________Business Email_________________
Insurance company______________________________Phone__________________________
Insurance Email____
Contact #___________________________Group #____________Subscriber #______________
Name (s) of other dependents under this plan_______________________________________

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Dental History

Patient name:______________________________ Date of birth:____________________
Last Name First Name Middle Inital

What would you like us to do today?____

Former Dentist:____Phone:_____________

Date of last dental care:_________________Date of last X-ray:___________________

Check Y for yes or N for no if you have or have not had the following:

- ◯Y ◯N Bad breath
- ◯Y ◯N Food collection between teeth
- ◯Y ◯N Periodontal treatment
- ◯Y ◯N Sensitivity to sweets
- ◯Y ◯N Bleeding gums
- ◯Y ◯N Grinding or clenching teeth
- ◯Y ◯N Sensitivity to cold
- ◯Y ◯N Sensitivity when biting
- ◯Y ◯N Clicking or popping jaw
- ◯Y ◯N Loose teeth or broken fillings
- ◯Y ◯N Sensitivity to hot
- ◯Y ◯N Sores or growths in mouth

How often do you brush?____________________How often do you floss?____________________

Any history of snoring or sleep apnea?____

How do you feel about the appearance of your teeth?____________________________________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ◯Y ◯N

Medical History

Physician's name:____Phone:_____________

Date of last visit_______Have you had any serious illnesses or operations? ◯Y ◯N If yes describe____________

Are you currently under physician care? ◯Y ◯N If yes, describe______________________

Have you ever had a blood transfusion? ◯Y ◯N if yes, give approximate date(s)______________

Have you ever taken Fen-Phen/Redux? ◯Y ◯N

Women: Are you pregnant? ◯Y ◯N Nursing? ◯Y ◯N Taking birth control pills? ◯Y ◯N

Check Y for yes or N for no if you have or have not had the following:

- ◯Y ◯N AIDS/HIV Positive
- ◯Y ◯N Anaphylaxis
- ◯Y ◯N Anemia
- ◯Y ◯N Arthritis, Rheumatism
- ◯Y ◯N Artificial Heart Valves
- ◯Y ◯N Artificial Joints
- ◯Y ◯N Asthma
- ◯Y ◯N Atopic (allergy prone)
- ◯Y ◯N Back problems
- ◯Y ◯N Blood disease
- ◯Y ◯N Cancer
- ◯Y ◯N Chemical dependency
- ◯Y ◯N Chemotherapy
- ◯Y ◯N Circulatory problems
- ◯Y ◯N Cortisone treatments
- ◯Y ◯N Cough, persistent
- ◯Y ◯N Cough up blood
- ◯Y ◯N Diabetes
- ◯Y ◯N Epilepsy
- ◯Y ◯N Fainting
- ◯Y ◯N Food allergies
- ◯Y ◯N Glaucoma
- ◯Y ◯N Headaches
- ◯Y ◯N Heart murmur
- ◯Y ◯N Heart problems
  Describe______________
- ◯Y ◯N Hemophilia/
  Abnormal bleeding
- ◯Y ◯N Herpes
- ◯Y ◯N Hepatitis B
- ◯Y ◯N High blood pressure
- ◯Y ◯N Jaw pain
- ◯Y ◯N Kidney disease or malfunction
- ◯Y ◯N Liver disease
- ◯Y ◯N Material allergies
  (latex, wool, metal, chemicals)
- ◯Y ◯N Mitral valve prolapse
- ◯Y ◯N Nervous problems
- ◯Y ◯N Pacemaker/Heart surgery
- ◯Y ◯N Psychiatric care
- ◯Y ◯N Rapid weight gain or loss
- ◯Y ◯N Radiation treatment
- ◯Y ◯N Respiratory disease
- ◯Y ◯N Rheumatic fever
- ◯Y ◯N Scarlet fever
- ◯Y ◯N Shingles
- ◯Y ◯N Sickle Cell Disease
- ◯Y ◯N Sinus Trouble
- ◯Y ◯N Spina Bifida
- ◯Y ◯N Stomach/Intestinal Disease
- ◯Y ◯N Stroke
- ◯Y ◯N Swelling of Limbs
- ◯Y ◯N Thyroid Disease
- ◯Y ◯N Tonsillitis
- ◯Y ◯N Tuberculosis
- ◯Y ◯N Tumors or Growths
- ◯Y ◯N Ulcers
- ◯Y ◯N Venereal Disease
- ◯Y ◯N Yellow Jaundice (Hepatitis A)

List drug allergies, if any:

____

List medications you are currently taking, if any:

____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

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Financial Policy

Thank you for choosing our office as your professional dental provider. We are committed to delivering successful high quality dentistry. It is important for you to understand that payment of your bill is considered part of your treatment.

A clear understanding of your financial responsibility is important to our professional relationship.

Full payment is due at the time services are rendered. We accept personal checks, Visa, MasterCard, Discover, and American Express. For extensive treatment, affordable financial arrangements can be provided through CareCredit and CitiHealth.

Insurance

Please be aware, insurance may not cover all provided services. If we accept assignments of benefits, we require immediate payment if there is a balance.

Any claims past 60 days will automatically become your financial obligation. *If an account has a balance that is not paid within 60 days, the account will be referred to collections. The account holder/debtor will incur all attorney, court, and collections costs.*

Some insurance companies reimburse based on an arbitrary or negotiated fee schedule which bears no relationship to the current standard and cost in this area. Your insurance policy is a contract between you, your employer, and the insurance company. This office is no party to that contract.

We cannot bill your insurance unless you provide the office with the appropriate information
Claims will only be submitted to the primary insurance.

Missed Appointments

We request 48 hours notice when canceling or rescheduling an appointment. Our policy is to charge for missed appointments at the rate of a normal office visit - $90 and $180 for major appointments. Please help us to serve you and others by keeping scheduled appointments.

Thank you again, for choosing our office for your professional dental needs and understanding our financial policy. Please let us know if you have questions or concerns.

I have read and fully understand the above financial policy.

____ ____________________
Signature of Patient and / or Responsible Party Date

____ ____________________
Witness Date