Welcome to FM Dental Group

We would like to take this opportunity to welcome you and thank you for joining our dental practice. We appreciate your confidence in us and will do everything possible to provide you with the finest dental care. Please fill out this form completely. The better we communicate, the better we can care for you.

Patient's Name _____

Date of Birth_____

Social Security Number_____

Driver's License Number_____

How Do You Wish To Be Addressed_____

Single__ Married__ Divorced__ Widowed__ Minor___

Residence—Street _____

City_____State___Zip_____

Telephone_____

Best Time to call_____

E-mail _____

Employer_____

Business Address_____

Business Telephone _____

Can we contact you at work? Yes____ No _____

Spouse's Name_____

Other Family Members With This Practice

_____

_____

Who is responsible for this account_____

Whom may we thank for your referral _____

In the event of an emergency, is there someone who we can contact? Name_____

Relationship _____

Telephone number _____

(IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST COMPLETE THE INFORMATION BELOW)

Parent's Name _____

Date of Birth_____

Social Security Number_____

Driver's License Number_____

Residence & Phone Number (if different from child)_____

_____

Method of payment:

- ☐ Insurance (**However, I am responsible for any deductible/estimated co-pay at the time of service**)
- ☐ **Payment in full** at each appointment (cash or personal check)
- ☐ **Payment in full** at each appointment (Visa, MC, Discover, Care Credit)
- ☐ I wish to discuss the Dental Office's Financial Policy (Please see our Office Policies form included with your packet for additional information)

Dental Insurance
Primary Coverage

Primary Subscriber's Name_____

Date of Birth_____

Social Security #_____

Employer_____

Name of insurance co._____

Address_____

_____

Telephone_____

Policy or Group #_____

Union or Local Group_____

Dental Insurance
Secondary Coverage

Secondary Subscriber's Name_____

Date of Birth_____

Social Security #_____

Employer_____

Name of insurance co._____

Address_____

_____

Telephone_____

Policy or Group #_____

Union or Local Group_____

HEALTH HISTORY

Correct answers to the following questions will allow FM Dental Group to treat you on a more individual basis, providing the care appropriate for your particular needs. All information is completely confidential.

Name _____ Birth date _____ Age _____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now?	❑	❑
2. Have you ever been hospitalized or had a serious illness?	❑	❑
If yes, explain _____		
3. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	❑	❑
If yes, explain _____		
4. (Women) Are you pregnant/trying to get pregnant? If so, give due date _____	❑	❑
Are you nursing?	❑	❑
5. Do you use tobacco in any form? If yes, how much _____	❑	❑

Do you have or have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
Sinus problems	❑	❑	Thyroid condition/goiter	❑	❑	Stent with releasing medication*	❑	❑
Stroke	❑	❑	Hypoglycemia	❑	❑	Arthritis/rheumatism	❑	❑
Headaches	❑	❑	Rheumatic fever	❑	❑	Artificial joints/limbs	❑	❑
Convulsions/epilepsy	❑	❑	Heart murmur	❑	❑	Osteoporosis	❑	❑
Numbness/tingling	❑	❑	Chest pain	❑	❑	Hepatitis A	❑	❑
Dizziness/fainting	❑	❑	Heart attack/trouble	❑	❑	Hepatitis B or C	❑	❑
Psychiatric treatment	❑	❑	High blood pressure	❑	❑	Radiation therapy	❑	❑
Emphysema	❑	❑	Mitral valve prolapse	❑	❑	Chemotherapy	❑	❑
Asthma/hay fever	❑	❑	Artificial heart valve*	❑	❑	Tumors or growths	❑	❑
Difficulty breathing while lying down	❑	❑	Pacemaker	❑	❑	Cancer	❑	❑
Diabetes	❑	❑	Heart surgery	❑	❑	HIV+	❑	❑
			Stent	❑	❑	AIDS	❑	❑

6. Are you **ALLERGIC** or have you ever experienced any reaction to the following?

Local anesthetics	❑	❑	Latex	❑	❑	Erythromycin	❑	❑
Penicillin	❑	❑	Aspirin	❑	❑	Other allergies _____		
Other antibiotics	❑	❑	Codeine	❑	❑			
Sulfa drugs	❑	❑						

7. Are you TAKING any of the following?

Antibiotics	❑	❑	Cortisone/steroids	❑	❑	Nitroglycerine	❑	❑
Sulfa drugs	❑	❑	Tranquilizers	❑	❑	Aspirin	❑	❑
Blood thinners (e.g., Plavix)	❑	❑	Insulin/other diabetes drugs	❑	❑	Osteoporosis drugs (e.g., Actonel,		
Blood pressure medication	❑	❑	Recreational drugs	❑	❑	Fosamax, Boniva, Reclast)	❑	❑
Thyroid medication	❑	❑	Digitalis/other heart medications	❑	❑	Other medication not listed here	❑	❑
Antihistamines/allergy drugs/cold remedies	❑	❑						

If yes to any of the above, list name of medication and dosage below:

1. _____
2. _____
3. _____
4. _____

8. Physician's Name _____ Phone _____
9. Have you ever had any serious trouble associated with previous dental treatment? _____
10. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____
11. Date of last dental visit _____
12. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
    If so, when? _____
13. Do you wish to talk with the dentist privately about any problem or concern? _____

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I understand that the information I have given today is correct to the best of my knowledge. I will not hold my dentist, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status at the next appointment.

Signature of Patient (Parent or Guardian) _____ Date _____

Doctor's Signature _____ Date _____

FM DENTAL GROUP PLLC
2301 COLUMBIA Pike, Suite 126
Arlington VA 22204
Telephone: 703-566-1121
Fax: 571-319-0953

CONSENT FOR TREATMENT

Patient Name (please print): _____

Date of Birth: _____

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment listed below. I understand my dental condition and have discussed several treatment options with the undersigned provider.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed below. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

I have discussed payment options and agreed upon a payment plan with the insurance company and/or with the undersigned provider.

Cleaning/Scaling - prevents gum disease and caries
Possible Complications: sensitive teeth, filling may be loosened, sensitive gums
Initials _____

X-Rays - needed to perform dental services
Possible Complications: exposure to radiation (minimal)
Initials _____

Local Anesthetics - avoids pain during treatments and procedures
Possible Complications: prolonged numbness beyond normal, nerve damage, bruising, allergic reactions up to and including death
Initials _____

Extractions - eliminates pain and infection, last resort for non-salvageable tooth
Possible Complications: fractured particles may remain, irritation to nerves causing temporary or permanent numbness, part of tooth my be lodged in sinus and require more surgery, bad infections may take a long time to cure, jaw may be stiff and hard to open for a time, if jawbone is weak it may fracture, excessive bleeding
Initials _____

Bonded Facings - improves appearance by covering spaces and gaps and discolored teeth
Possible Complications: edges can stain after time and need to be freshened, breakage can occur and result in need for remake, difficult to remove
Initials _____

Crowns-Caps-Inlays-Onlays - results in cosmetic improvement, repairs a tooth which is broken or badly damaged, prevents tooth from fracturing, eliminates spaces, holds a false tooth in place as part of a bridge, forms a solid structure to attach a partial denture, splints loose teeth to strengthen them,
used for tooth that can no longer be filled, completes an implant
Possible Complications: porcelain in crown may fracture, crown may come off and need to be cemented again or replaced, tooth may abscess and require further treatment, vital teeth prepared for crowns, caps or bridges may necessitate root canal at a later date
Initials _____

Fillings - eliminate decay, relieve pain, fill a hole or space in a tooth, protect a sensitive surface
Possible Complications: tooth may abscess from the filling, may fracture the tooth, tooth may be sensitive to temperature change, filling may fall out, in case of deep fillings tooth may eventually require root canal
Initials _____

Dentures, Bridgework, Partials - replaces missing teeth, results in cosmetic improvement, improves chewing efficiency, maintains structure of remaining teeth
Possible Complications: porcelain may fracture, prostheses may break and need to be cemented again or replaced, fit may change over time and require adjustment or new prosthesis, may damage adjoining teeth, metal clasps may be visible, decay may occur under clasps, partials may move when chewing
Initials _____

Root Canal - eliminates decay, relieves pain, saves the tooth
Possible Complications: non-diagnosable root fracture cannot be corrected and tooth must be extracted, non-diagnosable auxiliary canal cannot be corrected and tooth must be extracted
Initials _____

Gum Surgery - eliminates infections, reduces food pockets around teeth, helps eliminate tartar build-up, eliminates odors, reduces overgrown tissue
Possible Complications: may need to be repeated after time, pain after procedure, may lose teeth if gums don't respond to treatment
Initials _____

I confirm that I understand this form and the information contained therein.

_____
Signature of Patient or Legal Guardian Date

_____
Signature of Dentist Date

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Appointment Policy

We make every effort to see all patients on time and request that you extend the same courtesy to us by arriving on time for your appointment. Appointment times are reserved exclusively for you and will be scheduled at a time best suited for the treatment involved. Unannounced changes of appointments greatly affect other patients.

We will make at least one attempt to confirm your appointment two business days in advance. If you do not inform us that you will cancel or change your appointment time two days in advance then we will consider the appointment as broken. We reserve the right to charge a fee of $ 50.00 per broken appointment**.**
*(Please initial here)*_____

Financial Policy

In our efforts to keep dental costs to a minimum while maintaining a high-level of professional care, we have established the following payment policies:

1. For patients covered by insurance plans: We accept most PPO insurance plans. We also offer Out of Network services. We must verify eligibility and coverage prior to each appointment. Our office will file the claim for you and accept payment (assignment of benefits). You are responsible for deductibles and co-payments at the time services are rendered. Patients with more than two broken appointments within a one-year period may be considered for dismissal from the practice.

2. In the event your insurance plan does not cover a service or a portion of a service, you may be responsible for all remaining fees. **In the event that payment is not received from your insurance plan within 90 days from the date of treatment the remaining balance will become your responsibility.**

3. For patients who do not have insurance coverage, payment in full or the establishment of an agreed upon payment plan is expected at the time of treatment.

4. Payment may be made using cash, credit card (Visa, MasterCard, American Express), or personal check. A fee of $25.00 will be charged for any returned checks.

5. Payment plans are available for qualified patients. Arrangements must be made in advance of treatment. You may be eligible for up to 12 months payment plan without interest; most payment plans will require an appropriate down payment.

6. Outstanding account balances are due upon receipt of a statement from our office and may be subject to a finance charge of 1.5% monthly if not paid within 30 days.

7. Any charges incurred by this office related to collection of overdue accounts will be added to the patients account with a minimum charge of $25.00 per account plus any legal or court fees.

We hope this information is helpful in answering some of the questions you may have regarding our office policies. Please feel free to discuss any questions you may have with us.

I have read the above information and agree with the terms and conditions.

_____ _____ _____

Signature of Patient or Guardian /Responsible Party Date

_____

Print Name