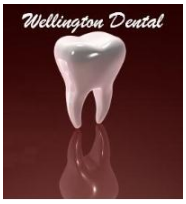

WELLINGTON DENTAL ASSOCIATES
10068 DUMFRIES ROAD
MANASSAS, VA 20110
(703) 330-0330

1) PATIENT INFORMATION			
Last Name	First Name	Middle Initial	Preferred Name
Street Address			Date
City		State	Zip
Date of Birth	Age	Social Security Number	E-Mail Address
Home Phone	Work Phone		Cell Phone
Gender		Marital Status	
☐Male ☐Female		☐Married ☐Single ☐Widowed ☐Divorced ☐Minor	
Employed By		Occupation	
Employer Address			Employer Phone
Who is responsible for this account?	Relationship to Patient		Social Security #
In the event of an emergency, who should be notified?	Relationship to Patient		Emergency Contact Phone Number
Whom may we thank for referring you?			

2) INSURANCE INFORMATION	
Name of Insured	Relationship to Patient (if other than patient)

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Is insured a patient?	Insured's Social Security Number	Insured's Date of Birth
☐Yes ☐No		
Dental Insurance Company Name	Group Number	Subscriber Number

3) MEDICAL HISTORY

Physician's Name	Date of Last Physical

Have you ever had any of the following? *(Only check boxes that apply)*

☐Heart Problems	☐Epilepsy	☐Special Diet
☐High Blood Pressure	☐Headaches	☐Swollen Neck Glands
☐Low Blood Pressure	☐Hepatitis or Jaundice	☐Rheumatic Fever
☐Circulatory Problems	☐Cancer	☐Sinus Problems
☐Nervous Problems	☐Psychiatric Care	☐A.I.D.S. or other
☐Radiation Treatments	☐Chronic Diarrhea	☐Immune Suppressive Disorders
☐Artificial Heart Valves/Joints	☐Allergies to Anesthetics	☐Stroke
☐Recent Weight Loss	☐Allergies to Medicine/Drugs	☐Ulcers
☐Back Problems	☐General Allergies	☐Venereal Disease
☐Diabetes	☐Blood Diseases	☐Chemical Dependency
☐Respiratory Disease	☐Arthritis	☐Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?	☐Yes ☐No	If Yes, describe below.
Have you ever responded adversely to any Medical or Dental Treatment?	☐Yes ☐No	If Yes, describe below.
Are you taking any Medication/s at this time?	☐Yes ☐No	If Yes, list them below.

Are you under the care of a Physician?	☐Yes ☐No	If Yes, describe for what conditions below.
If patient is a child, what is his/her weight?		lbs
Women: Do you suspect that you are pregnant?	☐Yes ☐No	
Women: Are you nursing?	☐Yes ☐No	
Is there anything else we should know about your Medical History?		

4) DENTAL HISTORY	
Reason for Today's visit	
Previous Dentist	Reason for changing dentists
Date of last dental visit	Date of last dental X-rays/cleaning
How often do you brush?	How often do you floss?
Place a mark next to "yes" or "no" to indicate if you have had any of the following	

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1.	Do your gums bleed while brushing or flossing?	Yes ☐	No ☐
2.	Are your teeth sensitive to hot or cold liquids/foods	Yes ☐	No ☐
3.	Are your teeth sensitive to sweet or sour liquids/foods?	Yes ☐	No ☐
4.	Do you feel pain to any of your teeth?	Yes ☐	No ☐
5.	Do you have any sores or lumps in or near your mouth?	Yes ☐	No ☐
6.	Have you had any head, neck or jaw injuries?	Yes ☐	No ☐
7.	Have you ever experienced any of the following problems in your jaw?		
	a. Clicking?	Yes ☐	No ☐
	b. Pain (Joint, Ear, Side of Face)?	Yes ☐	No ☐
	c. Difficulty in Opening or Closing?	Yes ☐	No ☐
	d. Difficulty in Chewing?	Yes ☐	No ☐
8.	Do you have frequent headaches?	Yes ☐	No ☐
9.	Do you clench or grind your teeth?	Yes ☐	No ☐
10.	Do you bite your lips or cheeks frequency?	Yes ☐	No ☐
11.	Have you ever had any difficult extractions in the past?	Yes ☐	No ☐
12.	Have you ever had prolonged bleeding following extractions?	Yes ☐	No ☐
13.	Have you had any Orthodontic work?	Yes ☐	No ☐
14.	Have you ever had instructions on the correct method of brushing your teeth?	Yes ☐	No ☐
15.	Have you ever had instructions on the care of your gums?	Yes ☐	No ☐

5) CERTIFICATION

The above information is accurate and complete to the best of my knowledge and is only for the use of my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have in the completion of this form.

Signature	Date

6) ASSIGNMENT & RELEASE

I, the undersigned, have insurance with _____ and assign all benefits directly to Dr. Yann and his Associates. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my Insurance submissions whether manual or electronic.

Signature	Date

7) MINOR/CHILD CONSENT

I, being the parent/guardian of _____do hereby request and authorize the dental staff and administration of anesthetics which are deemed advisable by the doctor,. In the case that I am not present at the actual appointment when the treatment is rendered I will send written consent of any treatment with the person that will be taking my child to the dental appointment.

Signature	Date

8) FINANCIAL AGREEMENT

I acknowledge that payment is due at time of treatment, unless other written arrangements are made. If the patient is a minor, I as the parent/guardian accept full responsibility for payment on services rendered for treatment of the minor/child. I acknowledge that there will be a $35.00 charge on all accounts that are past ninety (90) days and are sent to an outside collection company. I also acknowledge that there is a $45.00 broken appointment fee for all appointments broken without a 24 hour notice.

Signature	Date

9) PRIVACY POLICY

1. No information you give us will be given or sold to anyone else for commercial use.
2. You can obtain a copy of your treatment record. Parents can have a copy of their children's treatment records.
3. You can add information to your treatment record, especially new personal Medical conditions.
4. Any communication of treatment to other health practitioners (dental specialists, personal physician) or anyone else (insurance company, Public health, or law enforcement agency, etc.) will be recorded.
5. You can tell us who you specifically do not want any information discussed to such as a relative, business associates, etc.
6. Please tell us if there is something about your treatment or experience that was objectionable. We can only improve if we have your comments and suggestions.

I UNDERSTAND THE PRIVACY POLICY AS STATED ABOVE

Signature	Date

10) PATIENT RESPONSIBILITY

We take your insurance as a courtesy, but we're not fully responsible for your claims to be paid. It is the patient's responsibility to check back with our office after thirty (30) days to confirm that the insurance claim/s have been paid by your insurance company or to check with your insurance company. If we have to resubmit a dental claim on your behalf there will be an additional charge.

Signature	Date