Hamid Avin, DDS, PC & Maryam Avin, DDS
Sugarland Crossing
47100 Community Plaza, Suite 165
Sterling, VA 20164
(703) 444-5222

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

Cell Phone: _____Email Address _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Occupation: _____

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

Have you visited our website? _____

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

OTHER:

- ☐ _____
- ☐ _____

List medications Prescription & Non Prescription_____
_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please 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 of 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.

_____ Date:_____
Signature of patient, parent or guardian

Responsible Party Information

Name: _____ Driver License# _____

Social Security #: _____ Birth Date: _____

Phone - Home: _____ Work: _____Ext:_____ Other: _____

Address: _____
Street Apartment #

_____
City State Zip Code

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Insurance Information

Name of Insured: _____ _____ _____
. Last First MI

Insured's Birth Date: _____ ID # _____ Group # _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan : Name: _____ Phone: _____

Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in Cash or Credit Card at the time services are performed.

I understand that I am responsible for payment of the account for the patient named above. I understand that benefits may be afforded by an applicable insurance. Every effort will be made to collect the maximum benefits from insurance by Dr. Avin's office and myself. If a balance remains after insurance payment has been received and the applicable contract adjustments have been made according to the contract between Dr. Avin's office and my insurance company, I will make prompt payment of the remaining amount due.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I hereby give permission for Dr. Avin and his staff to discuss my treatment with my spouse/ partner in my presence or on the phone. Such discussion may contain information regarding my diagnosis and treatment. Such discussion will not be limited in any manner except that I must be present at such time any discussion take place or give permission on the phone. I understand that Dr. Avin and his staff will not provide any information or discuss my case with my spouse or partner except under these circumstances.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees of 33.3%, if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian