Main Street Family Dentistry

850-D East Main Street

Purcellville, VA 20132

Allen A. Zarrinfar D.D.S.

About You

Patient Name: _____Date:_____

Preferred Name: _____ Male____ Female____ Birthdate: ____/____/____

Social Security#_____ E-mail Address:_____

Mailing Address: _____

_____

City State Zip

Home Phone#: (____)_____ Work Phone #: (____)_____ Ext._____ Cell Phone #: (____)_____

Emergency Info

Whom should we contact? _____ Relation:_____

Home Phone #:(____)_____ Work Phone #: (____)_____ Ext.____ Cell Phone #: (____)_____

Who is your physician?_____ Physician's Phone #: (____)_____

Account Info

Person ultimately responsible for account

Name: _____ Relation: _____

Billing Address: _____

_____

City State Zip

Social Security #: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials

Insurance Info

Primary Dental Insurance

Company Name_____ Phone #: (_____)_____

Address:_____

_____

Insured's ID#: _____ Group #_____

Insured's Name:_____ Relation:_____ Date of Birth: _____/_____/_____

Insured's Employer:_____

Referral Information

Whom may we thank for referring you to our practice? ____ Another Patient / Friend ____ Website ____ Work _____ Newspaper _____Advertisement Other _____

Name of person or office referring you to our practice: _____

Dental Information

Reason for today's visit: ____ Exam ____ Emergency ____ Consultation ____ Cleaning

Are you in pain? ____ No ____ Yes How Long? _____

Please indicate any of the following problems:

___ Discomfort, clicking or popping in jaw. ___ Lost/Broken Filling(s) ___ Stained teeth

___ Red, swollen, bleeding gums. ___ Locking Jaw ___ Bad breath

___ Broken/ Chipped tooth ___ Sensitive tooth, teeth gums. ___ Blisters/Sores in or around the mouth.

___ Other: _____

Have you ever needed antibiotic pre-medication? ___ Yes ___ No ___ Don't know

Previous Dentist: _____ (_____)_____

Name Phone #

Last Dental Exam: _____/_____/_____ Last Dental X-Rays: _____/_____/_____

Medical History

What medications are you currently taking? ___ Aspirin ___ Blood Thinners ___ Insulin ___ Meds for Osteoporosis

___ Other(s) , please list: _____

_____

Do you have any of the following diseases, medical conditions, or procedures?

___ Heart Attack /Stroke	___ Thyroid Problems	___ Cancer/Tumors	___ Cosmetic Surgery
___ Heart Surgery/Pacemaker	___ Kidney Problems	___ Diabetes/Hypoglycemia	___ Chemotherapy
___ Heart Murmur	___ Liver Problems	___ Hepatitis	___ Asthma
___ Rheumatic Fever	___ Respiratory Problems	___ HIV+/AIDS/ARC	___ Difficulty Breathing
___ Mitral Valve Prolapsed	___ Sinus Problems	___ Arthritis/ Rheumatism	___ Shingles
___ Artificial Valves	___ Stomach Problems/Ulcers	___ Artificial Bones/Joints	___ Leukemia
___ Heart Disease	___ Psychiatric Problems	___ High/Low Blood Pressure	___ Anemia
___ Congenital Heart Defect	___ Venereal Disease	___ Fainting/Seizures/Epilepsy	___ Emphysema
___ Chest Pains	___ Alcohol/Drug Abuse	___ Severe/Frequent Headaches	___ Bleeding Problems
___ Tuberculosis, TB	___ Jaw Problems TMJ/TMD	___ Frequent Neck Pain	___ Glaucoma
___ Back Problems	___ Anxiety Disorder		

Please list any other surgeries or medical conditions you have or ever had: _____

_____ Do you Smoke/Tobacco use ___ Yes ___ No

Are you allergic to any of the following? ___ Latex ___ Penicillin/Amoxicillin ____ Dental Anesthetics

____ Others: _____

For Women: Are you taking birth control pills? ___ Yes ___ No Are you pregnant? ___ Yes ___ No

If yes, How long? _____ Are you nursing? ___ Yes ___ No

Consent

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 60 days of the date of service and no financial arrangements have been made you will be responsible for legal fees, collection agency fee, interest charges and any other expenses incurred in collection your account.
- I authorize this office to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date: _____/_____/_____

____ Adult Patient ____ Parent or Guardian ____ Spouse