**WELCOME**

**Montclair Family Dentistry**

Anh Zirnstein, DDS, PC

**PATIENT INFORMATION**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First and Middle

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex M F Age\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status S M W D

Phone # Home (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Who referred you to our dental practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEAD OF HOUSEHOLD AND INSURANCE INFORMATION**

**(Person responsible for account and/or subscriber)**

 Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First and Middle

 Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (if same as patient, leave blank)

 Sex M F Age\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_ Status S M W D

 Phone # Home (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (if same as patient, leave blank)

 Business Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **INSURANCE COMPANY (CARRIER)**

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address of Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Subscriber ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of other dependents under this plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Reason for visit (Chief Complaint)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Remarks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment is due in full at time of treatment, unless prior arrangements have been approved. There will be a $50.00 broken appointment fee if 24 hour notification is not given to our office. Please turn to the other side and fill out the medical history.**

**MEDICAL HISTORY**

Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you in good health? Yes No

Have you had any serious illnesses or operations? Yes No If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a physician? Yes No If yes, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an unusual reaction to an anesthetic or drug? Yes No

Have you ever had trouble with prolonged bleeding after surgery? Yes No

**For Women:** Are you pregnant? Yes No Taking birth control pills? Yes No

Please **check** if you ever had any of the following:

AIDS/HIV Hepatitis

Anaphylaxis High blood pressure

Asthma Kidney disease

Cortisone treatments Liver disease

Blood disease Thyroid disease

Cancer Artificial heart valves

Diabetes Artificial joins

Epilepsy Material allergies (latex)

Fainting Mitral valve prolapse

Glaucoma Anemia

Heart murmur Pacemaker/heart surgery

Heart problems Rheumatic fever

Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tuberculosis

Hemophilia/Abnormal bleeding Venereal disease

List any **medications** you are taking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any **drug allergies** you may have\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION**

I have received the information on the 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 treatment. If there is any chance in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist 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 the insurance.

 Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Montclair Family Dentistry**

Dr. Anh Zirnstein DDS PC

Dr. Joseph Kim DMD

Dr. Christopher Beiner DDS

16150 Country Club Drive

Dumfries, VA 22025

I acknowledge that I have read a copy of Anh Zirnstein, DDS Notice of Privacy Practices for HIPPA regulations.

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Montclair Family Dentistry

16150 Country Club Drive

Montclair VA 22025

703-670-4838

We schedule our appointments so that each patient receives the right amount of time to be seen by our doctors and staff. That’s why it is important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments Montclair Family Dentistry will call or send an email remainder 2 days in advance of the appointment time.

If your schedule changes and you cannot keep you appointment, please contact us so we may reschedule you, and accommodate other patients as needed. As a courtesy to our office as well as to those patients who are waiting to schedule with the doctor, please give us at least **24 hour** notice.

If you do not cancel or reschedule your appointment with at least 24 hour notice, we may assess a **$50** “no-show” service charge to your account. This “no-show charge” is not reimbursable by your insurance company. You will be billed directly for it. After three consecutive no-shows to your appointment, may decide to terminate its relationship with you.

Anh N. Zirnstein, DDS. PC

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date

**FINANCIAL AGREEMENT**

Please initial the section that applies to you:

\_\_\_\_\_ **DENTAL INSURANCE PAYMENT**

Initials

\_\_\_\_\_\_ 20% deposit upon service/filling \_\_\_\_\_\_ 40% deposit upon service/RCT

 Initials Initials

 \_\_\_\_\_\_ 30% deposit upon service/Crown

 Initials

\_\_\_\_\_ **IMPLANT PATIENT WITH DENTAL INSURANCE-** \_\_\_\_\_ $440 deposit due upon service

Initials Initials

I understand the following services are generally not covered by dental plans and that I will be responsible for payment in full at the time of service - \_\_\_\_\_ 3d Cone Bean Initials

\_\_\_\_\_ **NON-COVERED SERVICES** – Payment in full due upon service

Initials

**INSURANCE AND BILLING DISCLAIMER**

**We are unable to make any guarantee of insurance payments. I understand that I am responsible for knowing the benefits and coverage of my insurance plan. The deposit collected today is a percentage of the total cost of the services performed. After your insurance company processes your claim(s), there may still be a balance due. Any remaining balance will be billed promptly.**

\_\_\_\_\_ I authorize any remaining balance(s) be communicated by mail, electronically through

Initials email.

**IF A REFUND IS NECESSARY, TO WHOM SHOULD THE CHECK BE MADE OUT TO**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAYMENT MADE BY CHECK: A $ 50 fee will be charged to my account for returned check(s).

**ASSIGNMENT OF BENEFITS**: Insurance: We are happy to file the necessary claim from on your behalf. My signature below is authorization for dental and/or medical claims to be filed on my behalf. I also authorize that payment be made directly to Montclair Family Dentistry.

**DIVORCE DECREES**: In case of services provided for minors, the individual who initiates services for the child will be responsible for payment. **We do not bill another individual for payment**. If divorce decree requires the other parent to pay all or part of the treatment, it is the authorizing parent’s responsibility to collect from the other parent.

**COLLECTIONS POLICY**: If collection procedures are required for unpaid balances, I am responsible for **ALL COSTS** of collections **INCLUDING BUT NOT LIMITED TO** reasonable attorney fees which will represent 30% of the outstanding balance and court costs.

**RESCHEDULE/CANCELLATION/NO SHOW POLICY** – We ask for at least 24 hour notice for any cancellations and reserve the right to obtain a deposit for non-show, cancellation or rescheduled appointment of $50.

**I hereby certify that I have fully read the above and agree with all the terms and conditions.**

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian: (18 years or older)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Additional Responsible Party: (18 years old)