Family Dentistry
Far Soltanian, DDS, PC

WELCOME TO OUR PRACTICE! We appreciate the confidence you have placed in us to provide Dental Care to you. All information on this form is necessary for our records and is strictly confidential

Patient is: ☐ **Policy Holder** ☐ **Responsible Party** ☐ **Neither** ***How did you hear about us?*** ________________

Title: (Circle One) Mr. Mrs. Ms. Dr. Other _________ **Male/ Female**: (Circle One)

Patient Information:

First Name ______________________ Last Name ______________________ MI ________

Address ______________________ City ____________ State ______ Zip Code __________

Home Phone ______________ Work Phone ______________ Cell Phone ________________

Date of Birth ___________ Age _____ SS # ________________ E-mail ____________________

Student Status: FT / PT (if pt. is over 18 and covered under parent's plan) School Name __________________

Employer ____________________ Pref. Pharmacy ______________ Phone # ____________

Emergency Contact __________________ Relationship ______________ Phone # ____________

Responsible Party Information, if other than patient:

First Name ______________________ Last Name ______________________ MI ________

Address ______________________ City ____________ State ______ Zip Code __________

Home Phone ______________ Work Phone ______________ Cell Phone ________________

Social Security # ________________________ Employer ____________________________

Policy Holder Information:

Policy Holder Name ___________________________ SS# __________________________

DOB ___________ Relationship to Patient ______________ Employer ____________________

Ins. Company ______________________ Ins. Co. Phone # __________________________

Please present Responsible Party's Driver's License and a copy of Insurance Card if you have Dental Insurance

PATIENT MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will receive. **Thank you for answering the following questions.**

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain ____________________

Have you ever bee hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain ____________________

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain ____________________

Are you taking any medications, pills or drugs? ☐ Yes ☐ No Please List ____________________

Are you on a special diet? ☐ Yes ☐ No If yes, please explain ____________________

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Are you on an aspirin regimen? ☐ Yes ☐ No

Women: Are you

☐ **Pregnant/Trying to get pregnant?** ☐ Nursing?
☐ **Taking Oral Contraceptives?**

Are you allergic to the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain

____

Do you **have, or have you had, any of the following?**

___ AIDS/HIV Positive	___ Cold Sores/Fever Blisters	___ Heart Pace Maker	___ Leukemia
___ Anemia	___ Congenital Heart Disorder	___ Heart Disease	___ Liver Disease
___ Artificial Hear Valve	___ Convulsions	___ Hemophilia	___ Low Blood Pressure
___ Artificial Joint	___ Diabetes	___ Hepatitis A	___ Mitral Valve Prolapse
___ Asthma	___ Epilepsy or Seizures	___ Hepatitis B or C	___ Pain in Jaw Joints
___ Blood Disease	___ Excessive Bleeding	___ Herpes	___ Psychiatric Care
___ Blood Transfusion	___ Fainting/Dizziness	___ High Blood Pressure	___ Radiation Treatments
___ Cancer	___ Frequent Headaches	___ Hives or Rash	___ Rheumatic Fever
___ Chemotherapy	___ Heart Attack/Failure	___ Hypoglycemia	___ Sinus Trouble
___ Chest Pains	___ Heart Murmur	___ Kidney Problems	___ Tuberculosis

Have you ever had a serious illness not listed above? ___ Yes ___ No If yes, please explain ____________________

Additional Comments ____________________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to advise the dental office of any changes in my medical status.

Signature of **Patient Parent or Guardian** ____________________ **Date** __________

Signature of **Clinical Team member reviewing** ____________________ **Date** __________

Information on Office Guidelines

Initial

Insurance: We understand the value of insurance and will assist you in obtaining your maximum benefit. You must realize, however, that your benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. We will gladly file your insurance claims and estimate your co-payment amounts. Deductibles and co-payments are due on or before the day of the treatment. Our estimates are subject to final approval by your insurance company and could therefore change the amount due to our office. You are responsible for monitoring your own insurance. We are not responsible if payable benefits exceed your annual maximum. ***If payment is not received by your insurance company*** within thirty (30) days of the treatment, the balance due on your account will be your responsibility.

Secondary Insurance: We will be happy to file any secondary insurance once you have paid the balance due after the primary insurance payment is made. We will direct the Secondary Insurance Company to pay benefits directly to you.

Payment Options: In order to assist you with the investment in your dental health, we are providing the following options from which you may select to best meet your financial needs. We will be happy to work with you to plan out the most appropriate arrangements for your budget.

1. Cash or money order
2. Personal Checks (with proper I.D.)
3. Debit Cards
4. Credit Cards (Master Card, Visa, Discover & American Express
5. Third Party Financing (available to qualified applicants) in the form of Short term Interest Free or Low Interest 24 to 48 month Term Options.

Appointment Guidelines: In an effort to serve the treatment needs of all our patients in a timely manner, we must adhere to the following scheduling guidelines:

1. Appointments under one (1) hour in length require at least a twenty four (24) advance notice to cancel. There is a charge of $25.00 per half hour billed to your account for failure to give the requested notice.
2. Appointments over one (1) hour in length require an advance payment in the amount of ½ of the fee or the entire patient co-pay. These appointments require a forty eight (48) hour notice to cancel or reschedule. The advance payment will be forfeited for failure to give the requested notice.

We understand that emergencies can arise and we will make every effort to recognize extenuating circumstances regarding cancellations.

Account Guidelines: There will be a $30.00 charge for any check returned by your bank for any reason. Accounts that become past due will receive service charges in the amount of 1 ½ % per month, 18% per annum, on any unpaid balance. If this account is referred to a collection agency or our attorney for collection, patient will be responsible for the cost of collection including, but not limited to 33 1/3% collection costs and/or attorney's fees on the balance owed in addition to any court costs.

I authorize payment directly to Dr. Soltanian for the benefit otherwise payable to me under the terms of any insurance. I understand that I am responsible for all charges arising from the treatment of the below-named patient and any insurance payments will be credited to the account.

I understand, in accordance with Section 32. 1-45.1 of the code of Virginia, 1950, as amended, that if the provision of health care services to the patient at this office directly exposes any person by or under the direction and control of the healthcare provider to the patient's body fluids in a manner that may transmit immunodeficiency virus or HIV, then the patient shall be deemed to have consented to testing for infection with HIV, and or Hepatitis B, and to the release of such test results to the person(s) exposed.

I HAVE READ, UNDERSTAND AND AGREE TO THE GUIDELINES AS DESCRIBED ABOVE.

Signature ______________________________ Date ____________________

If you are not the patient, please state your relationship to the patient: ____________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT

NAME:____________________________**SS#**________________________________

ADDRESS:___________________________PHONE:_________________________

PURPOSE OF CONSENT: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, and health care operations. In accordance with Section 32. 1-45.1 of the code of Virginia, if any person under the direction of the health care provider is exposed to a patient's body fluids in a manner that may transmit immunodeficiency virus or HIV, the patient shall be deemed to have consented to testing for infection with HIV, and or Hepatitis B, and to release results to the person (s) exposed.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of of our Privacy Practices at any time.

RIGHT TO REVOKE: Your have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to this office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,___________________________________ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment.

Signature:_____________________________________ Date:______________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:______________________Relationship_______________________

FAR SOLTANIAN, D.D.S., P.C.

Springfield Commons
3944 Springfield Road
Glen Allen, VA 23060
Telephone: (804) 270-5214
Fax: (804) 270-6046
www.fsdent.com

Please be advised your Insurance is a contract between you, your employer and the insurance company. We are not a part of the contract. We will gladly assist you by estimating copay amounts and filing claims on your behalf. (Deductibles and copays are due when treatment is scheduled.) Our estimates are subject to final approval of your insurance company therefore the amount due to our office could change. You are responsible for monitoring your own insurance benefits. Any changes to your policy need to be brought to the attention of the office staff. If payment is not received within 45 business days you are responsible for the account balance.

A fee of 2% is added to all unpaid balances after thirty days from the first notice. If the account is referred to collections you will be responsible for the cost of collections. A fee of $75.00 for returned checks is imposed.

In order to adhere to the scheduling needs of all our patients it is necessary to enforce our cancellation policy:

WE REQUIRE 48 HOURS NOTICE TO CANCEL OR RESCHEDULE APPOINTMENTS.

The advance payment will be forfeited for failure to give us the requested notice. We ask that you value our Doctors time as we regard you as one of our highly valued patients with this time devoted just to you.

I authorize payment directly to Dr. Far Soltanian for the benefits otherwise payable to me under the terms of any insurance.

Signature:____________________________ Date:____________________

Guardian:____________________________