Dental group of Tysons
Patient Information Form

Patient Name: ____ Date:__________________

Address:____ Email: ______________________

City and State:____ Zip: ___________________

Home Phone: __________________________ Work Phone:____________________________

Patient's Social Security # _______________________ Date of Birth:____________________

Married: ____________ Single: ____________ Divorced: ____________ Widow: ___________

Patient's Employer Name and Address: ____

City and State: ____ Zip: __________

Persons responsible for payment of this account:______________________________________

Payment of choice: _______________ Cash______________ Check ______________ Visa/MC

Name of Spouse or Parent:______________________________ SS#:____________________

Address (if different from above):____

City and State: ____ Zip: __________

Home Phone: __________________________ Work Phone:____________________________

Spouse's Employer Name and Address: ____

City and State: __________________________ Work Phone:___________________________

In case of emergency, who should we notify?____

Relationship: _____________________________ Phone: ______________________________

How did you hear about our office? ____

Do you have insurance? Yes ____________ No ____________

Name of insured: ________________________ SS#: ______________ D.O.B. ____________

Relationship to Patient: ____

Please fill out insurance information sheet so we can submit.

TERMS AND CONDITIONS

In the event of a broken appointment with less than 24 hours notice, a fee may be applied to your account. I understand payment or co-payment (Insurance patients) is due and payable in full at each appointment visit. In the event that this account becomes past due, the doctors, their assigns, or lawful agents may consider the account in default and pursue collection procedures. If my account is past due, I agree to pay 1.5% interest per month (18% annum) on the unpaid balance from the due date, in addition to collection cost. Collection cost may include, but are not limited to, court filing fees, service or pressing costs, and reasonable attorney fees of 30% of unpaid principle, or $50.00, whichever is greater. Any returned check will be charged a processing fee of $25.00.

Signed: ____ Date: ________________________