Stonewall Dental Associates

8719 Stonewall Rd
Manassas, VA 20110
(703) 368-1000

PATIENT INFORMATION

Patient Name _____ SSN# _____
First Name Middle Name Last Name (Nick Name)

Address _____
Street & Number City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

e-mail address: _____ Sex □ M □ F Age_____ Birthdate_____

Student's School: _____ Grade: ____ □ Single □ Married □ Widowed □ Partnered □ Divorced

Patients' Employer: _____ Occupation: _____

WHOM MAY WE THANK FOR REFERRING YOU?
□ Doctor/Dentist _____ □ Patient _____ □ Other _____

Emergency Contact: _____ Phone #_____ Relation to patient: _____

FOR DEPENDENTS UNDER 18

Patient Lives With: _____

Mother: _____ DOB:_____ SSN#_____ License #_____ State____

Employer: _____ Occupation_____ Work Phone_____

Father: _____ DOB:_____ SSN#_____ License #_____ State_____

Employer: _____ Occupation_____ Work Phone_____

Guardian: _____ DOB:_____ SSN#_____ License #_____ State_____

Employer: _____ Occupation_____ Work Phone_____

Guardian relation to patient: _____

AUTHORIZATION FOR DENTAL TREATMENT

I authorize myself or my child, a minor, to have treatment rendered by the doctors and the staff of Stonewall Dental Associates. I authorize the following people, other than myself, to bring my child to your office for dental care:

***Patient Signature**: _____

I agree to be responsible for this account and arrive on time for scheduled appointments. Appointments are the responsibility of the patient. Our practice provides courtesy calls 2 business days in advance of your scheduled appointment. I understand changes or cancellations of my/ my child's appointment require 2 days business notice. A fee of $75 will be charged as a broken appointment fee for ANY cancellations WITHOUT 48 hour business day notice. This fee is for regular appointments that DON'T include surgery services. There will be a fee of $150 for ANY cancelled surgery appointment WITHOUT 48 business day notice. NO charge will be made for rescheduling an appointment, provided **48 business hours** notice is given.

I agree to be responsible for **all charges,** including those not covered by my insurance company. I understand that payment is due at the time of service. We accept cash, personal checks, Visa, MasterCard, Discover and Care Credit (healthcare financing). There will be an 18% APR added to any account 60 days or more past due irregardless of insurance coverage. A $30 bank fee is accrued on accounts for returned checks. In the unlikely event that my account is placed for overdue collections, I understand that I must pay all costs and expenses incurring on my behalf for the full collection of the account. When applicable, delinquent accounts are reported to the Credit Bureau.

***Patient Signature_____ Date: _____**

INSURED PARTY'S INFORMATION

Insured Person _____ Relation to Patient _____

Birthdate of Insured _____

Address (if different from pt) _____

City State Zip

_____

Home Phone Work Phone Cell Phone

_____

Insurance Company City State Zip

_____

Group # ID# Insured Social Security #

We are **participating providers** with Anthem BCBS, Carefirst BCBS, Careington (PPO Only), Cigna, Delta Premier, Delta PPO with Premier Benefit Options, GEHA, Guardian, Humana, Metlife PDP Plus Network, United Concordia, United Healthcare, Veteran Affair's Department (Community Care) and Smiles for Children (Medicaid for 21 and under; also pregnant member's plan). We are considered **non-participating** providers with **ALL** other insurance companies, including Delta HMO plans. Insurance may be filed on your behalf as a courtesy. We will assist you in answering any questions you may have regarding your insurance. Reimbursements for treatment will be made at the rate your employer has purchased for you. I understand that I have a contract with my insurance carrier and am responsible for knowing what my plan benefits and limitations are.

Initial x_____

There can be no guarantee of payment by any insurance plan. I accept full responsibility for payment that may not be covered by my insurance carrier when services are rendered. I understand that any remaining balance after my insurance plan makes payment is my responsibility. Any services not paid for by my insurance plan within 45 days will become my responsibility.

Initial x_____

Insurance Authorization
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 my insurance. Stonewall Dental will file electronic/paper based insurance claims for any primary/secondary insurance companies. I understand that Stonewall Dental makes no guarantee of any insurance payments for any dental services.

Initial x _____

Insurance Authorization for Direct Assignment
If applicable, I authorize my insurance company to pay Stonewall Dental all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions by Stonewall Dental and/or the doctors of this group.

Initial x _____

DENTAL HISTORY

What brings you to our office today? _____

Are you in discomfort today? _____ Former Dentist? _____ Date of last visit? _____

Have you had any dental problems in the past? _____

Does your child have any mouth or speech habits (Sucking Fingers/Pacifier? _____

Do you have well water? _____ Do you use any fluoride supplements? _____

MEDICAL HISTORY

Family Dr./Pediatrician _____ City/State _____ Phone _____ Date of last visit _____

Have you had any illness or operations in the last 10 years? ☐ yes ☐ no When? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ yes ☐ no Date _____

Women: **Are you pregnant?** ☐ yes ☐ no **Nursing?** ☐ yes ☐ no **Taking birth control pills?** ☐ yes ☐ no

Check (✓) if you have any of the following:

☐ADD/ ADHD	☐ Circulatory problems	☐ Herpes	☐ Rheumatic Fever
☐ AIDS/ HIV	☐ Cortisone treatments	☐ High Blood Pressure	☐ Scarlet Fever
☐ Allergies / sinus problems	☐ Developmental disorders	☐ Jaw pain	☐ Sickle Cell Anemia / Trait
☐ Anaphylaxis	☐ Diabetes	☐ Kidney disease / dialysis	☐ Skin rash
☐ Anemia	☐ Drug / Alcohol use	☐ Liver disease	☐ Special Needs Patients _____
☐ Arthritis / Rheumatism	☐ Epilepsy	☐ Material allergy (latex,	☐ Stroke
☐ Artificial heart valves	☐ Fainting	wool, metal, chemicals)	☐ Surgical implant
☐ Artificial joints	☐ Food allergies _____	☐ Intellectual Disability	☐ Swollen feet / ankles
☐ Asthma	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ TB / or persistent cough
☐ Autism	☐ Headaches	☐ Pacemaker	☐ Thyroid disease
☐ Blood Disorders	☐ Hearing Impaired	☐ Physical handicaps	☐ Tobacco habit
☐ Cancer/ Tumors	☐ Heart problems _____	☐ Psychiatric care	☐ Tonsillitis
☐ Cerebral palsy	☐ Hemophilia	☐ Radiation TX	☐ Ulcer
☐ Chemotherapy	☐ Hepatitis	☐ Respiratory	☐ Venereal disease

☐ PLEASE CHECK BOX IF NONE OF THESE CONDITIONS APPLY TO YOU AND INITIAL HERE: _____

Please list any health problems not listed above: _____

List any medications you are currently taking on a routine basis: _____

List any drug allergies, if any: _____

Doctors Notes: _____

I understand the above information is necessary to provide me / my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency to release such information to you. I will notify the doctor of any changes in my / my child's health or medication. I authorize release of any records or information to coordinate my / my child's healthcare with other medical professionals. I also acknowledge receipt of Stonewall **Dental Associates.**

***Patient /Parent or Guardian Signature _____ Date _____**

Doctor Signature _____ Date _____