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
- ☐ Anaphylaxis
- ☐ Asthma
- ☐ Cortisone treatments
- ☐ Blood disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart murmur
- ☐ Heart problems
  Describe_____
- ☐ Hemophilia/Abnormal bleeding
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Artificial heart valves
- ☐ Artificial joins
- ☐ Material allergies (latex)
- ☐ Mitral valve prolapse
- ☐ Anemia
- ☐ Pacemaker/heart surgery
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ 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)