Q Smiles Dental

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Welcome!

Dental Registration and History

Please don't hesitate to ask if you have any questions

1. PATIENT INFORMATION

Patient Name _____
Last Name First Name Middle Initial

Date _____ Birthday _____

SS# or Insurance ID# _____ Sex ☐ M ☐ F

Address _____

City _____ State _____ Zip _____

Home Tel _____ Work Tel _____

Mobile # _____ Occupation _____

Email _____ Marital Status _____

Referral Source _____

Notes _____

2. EMPLOYER / SCHOOL

Employer/ School Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Notes _____

3. EMERGENCY CONTACT

Emergency Contact Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Relationship _____

4. INSURANCE INFORMATION

Responsible Party Name _____

Relationship to Patient _____

Insurance Company _____

Subscriber Name _____

Group # _____ SS# _____

Birthday _____ Other Coverage ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with: _____

and assigned directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information in the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan to completed or one year from the date signed below.

Signature _____ Date _____

5. DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Tel _____ Last X-Ray Date _____

Last Cleaning _____ Last Dental Visit _____

Do you feel pain ☐ Yes ☐ No if yes please describe _____

Do you feel numbness, swelling, or any other sensitivity? ☐ Yes ☐ No if yes please explain _____

Additional comments about your past dental history _____

Please Continue to 2nd Page