CAPITAL DENTAL CENTER

Kiarash Saba, DMD
1712 Eye Street NW Suite 1000, Washington, DC 20006
Phone: (202) 296-8252

Today's Date: _____

PATIENT INFORMATION

Name: _____
Mr. / Mrs. / Ms. / Dr. First MI Last

How would you like to be addressed by our staff? _____ Referred By: _____

DOB: ___/___/___ Age: ___ SSN: _____ Sex: ___ Marital Status: ___

Home Address: _____
Apt/Unit # City State Zip

Home # ( )_____ Work # ( )_____ Cell # ( )_____

Employer: _____ Email: _____

Insurance & I.D #: _____Insured (If not self) Name _____
Insured D.O.B & relationship _____

Physician's Name: _____ Address: _____

Emergency Contact: _____ Relationship_____Phone # ( )_____

DENTAL HISTORY

Former Dentist: _____ Approx. date of last dental visit: _____

PLEASE CHECK ONLY THOSE THAT APPLY

___ Bad breath
___ Blisters on lips or mouth
___ Chew on one side of mouth
___ Dry mouth
___ Food collection between teeth
___ Clench or grind teeth
___ Growths / sore spots in mouth
___ Gums swollen / tender / bleeding
___ Loose teeth / broken fillings
___ Pressure (Biting) sensitivity
___ Temperature sensitivity
___ Head, neck, jaw pain / aches
___ Lip / cheek biting
___ Nitrous Oxide
___ Orthodontic treatment
___ Periodontal treatment

*How often do you floss? ___/ day How often do you brush? ___/ day

Any dental issue(s) you wish to discuss with Dr. Saba: _____

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MEDICAL HISTORY

Are you in good health? Yes ___ No ___

Are you taking any prescription / over-the-counter supplement drug(s)? Yes___ No___

If yes, please list all: _____

Do you smoke or use tobacco in any form? Yes___ No___ If yes, how much? _____ /per _____

For Women: Are you pregnant? Yes___ No___ If yes, Week #: _____ Are you nursing? Yes___No___

PLEASE CHECK ONLY THOSE THAT APPLY

___ Abnormal Bleeding
___ Alcohol / Drug Abuse
___ Anemia
___ Arthritis
___ Artificial Joints / Valves
___ Asthma
___ Blood Transfusion
___ Cancer / Chemotherapy
___ Colitis
___ Congenital Heart Defect
___ COVID-19
___ Diabetes
___ Difficulty Breathing / Emphysema
___ Epilepsy
___ Fainting Spells
___ Frequent Headaches
___ Glaucoma
___ Hay Fever
___ Heart Attack
___ Heart Murmur
___ Heart Surgery
___ Hemophilia
___ Hepatitis
___ Herpes / Fever Blisters
___ High Blood Pressure
___ HIV+ / AIDS
___ Kidney Problems
___ Liver Disease
___ Low Blood Pressure
___Lupus
___ Mental Disorder
___ Mitral Valve Prolapse
___ Pacemaker
___ Radiation Treatment
___ Rheumatic / Scarlet Fever
___ Seasonal Allergies
___ Seizures
___ Shingles
___ Sickle Cell Disease / Traits
___ Sinus Problems
___ Stroke
___ Thyroid Problems
___ Tuberculosis (TB)
___ Ulcers
___ Venereal Disease

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following? Latex ___ Sulfur __ Amoxicillin __ Ibuprofen ___Keflex ___
Aspirin ___ Codeine ___ Dental Anesthetics ___ Erythromycin ___ Penicillin ___ Tetracycline ___ Other _____

Please list any other medication(s) / material(s) (foods) that you are allergic to: _____

_____ _____
Patient's Signature Date

_____ _____
Dentist's Signature Date

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FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges incurred on my account, whether covered by my insurance company or not. These charges are to be paid at the time services are rendered unless submitted to an insurance company who has agreed to make payments directly to Dr. Saba. If I fail to inform the office of any changes in my insurance coverage, I understand that I am financially responsible for all charges incurred.

I understand that Dr. Saba's business office will attempt to estimate my patient responsibility based on information provided by my insurance company and myself. I realize that this is only an estimate and that due to specific clauses and exclusions in my policy which Dr. Saba's office may not be aware of, some procedures may either be covered at an alternate benefit level or possibly not be covered at all. Furthermore, I understand that I can request a pre-treatment estimate of benefits prior to beginning treatment to determine dental benefits.

In the event collection proceedings are instituted to enforce payment of fees, I agree to pay any attorney fees and associated court costs necessary for collection. In addition, I understand that there is a $35 fee for returned checks.

If you request copies of entire patient chart, there is a charge of $50 for a complete copy of patient's chart for expenses such as copies and staff time. We will provide your dental X-rays at no charge after receiving the Records/X-ray of Release Form.

If I will be unable to keep my scheduled appointment, I agree to give 48 business hours notice. Otherwise, I may be charged $75 for the appointment missed. (Extensive procedure cancellation charge may be higher due to the greater length of time reserved.)

_____
Print Full Name

_____
Signature

_____
Date