Reset Form Print Form

Falls Church Dental Care

Dr. Leila Saba, DDS
7115 Leesburg Pike, Suite 205, Falls Church, VA 22043, 703.534.3444

Patient Information

Name: _____ (Last name) _____ (First name) _____ (Middle Initial)

Address _____ (Street Address) _____ (City) _____ (State) _____ (Zip code)

Gender : ☐ male ☐ female Status: ☐ single ☐ married ☐ divorced

Date of Birth: ____ / ____ / _____ Age:____ E-mail : _____

Social Security Number: _____ - _____ - _____

Home phone: (___) - _____ - _____ Work Phone: (___) - _____ - _____ Cell: (___) - _____ - _____

Emergency Contact: _____ (Last name) _____ (First name) Telephone: (___) - _____ - _____

- How did you hear about our office? ☐ Insurance company/website ☐ Phone book ☐ Advertisement ☐ Referral by family member/friend
- If referred by family member or friend please provide name: _____
- Fill out this section if the patient is a minor or has legal guardian

Legal Guardian: _____ Relationship to patient: _____

Insurance Information

Insurance Company Name: _____ Group Number: _____ Policy Number_____

Address _____ (Street Address) _____ (City) _____ (State) _____ (Zip code)

Name of Employer: _____ Telephone: (_____) - _____ - _____

- Fill out this section if the insurance coverage for the patient is provided by another family member

Name of Insured: _____ (Last name) _____ (First name) Relationship to Patient: _____

Social Security Number: ____ - ____ - _____ DOB: ___ / ___ / _____ Is he/she currently a patient of our practice? ☐Yes ☐ No

Patient Medical History

1. Are you under medical treatment now? ☐Yes ☐ No
2. Have you been hospitalized in the past 5 years for any serious or surgical operation? ☐Yes ☐ No
3. Do you use tobacco? ☐Yes ☐ No
4. Do you use any controlled substance(s)? ☐Yes ☐ No
5. Are you wearing contact lenses? ☐Yes ☐ No
6. If you are currently taking medications please list: _____
7. If you are allergic to any of the following, please specify:

☐ Penicillin or any other Antibiotics	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Barbiturates	☐ Sedatives	☐ Latex Rubber

8. Do you have any of the following conditions, please specify:

☐ High Blood pressure	☐ Diabetes	☐ Radiation Therapy
☐ Heart Attack	☐ kidney Diseases	☐ Glaucoma
☐ Rheumatic Fever	☐ Heart Murmur	☐ Recent Weight Loss
☐ Swollen Ankles	☐ Thyroid Problem	☐ Liver Disease
☐ Fainting/Seizures	☐ Heart Disease	☐ Heart Trouble
☐ Asthma	☐ Cardiac Pacemaker	☐ Respiratory Problems
☐ Low blood Pressure	☐ Angina	☐ Mitral Valve Prolapse
☐ Epilepsy/Convulsions	☐ Anemia	☐ AIDS or HIV infection
☐ Leukemia	☐ Emphysema	☐ Other: _____

9. If you are allergic to any of the following, please specify:
   a. Are you Pregnant or think you may be pregnant? ☐Yes ☐ No
   b. Are you nursing? ☐Yes ☐ No
   c. Are you taking oral contraceptives? ☐Yes ☐ No

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Patient Dental History

1. Which of the following services are you interested in? (checkmark all that applies)

☐ Regular cleaning & check-up ☐ Cosmetic dentistry ☐ Bleaching ☐ Orthodontics (braces)
☐ Reconstructive work (crown & bridges) ☐ Implants ☐ Sedation dentistry ☐ Consultation

2.	Do you like your smile?	☐ Yes	☐ No		
3.	How often do you brush?	☐ More than once a day	☐ Once a day	☐ Few times a week	do not brush
4.	How often do you floss?	☐ More than once a day	☐ Once a day	☐ Few times a week	do not floss
5.	Are your teeth sensitive to hot or cold liquids/foods?	☐ Yes	☐ No		
6.	Are your teeth sensitive to sweet or sour liquids/foods?	☐ Yes	☐ No		
7.	Do you feel pain to any of your teeth?	☐ Yes	☐ No		
8.	Do you have any sores or lumps in or near your mouth?	☐ Yes	☐ No		
9.	Do your gums bleed while brush or floss?	☐ Yes	☐ No		
10.	Do you Clench or grind your teeth?	☐ Yes	☐ No		
11.	Do you have frequent headaches?	☐ Yes	☐ No		
12.	Have you had any orthodontic treatment?	☐ Yes	☐ No		
13.	Do you have any problems opening or closing your jaw?	☐ Yes	☐ No		
14.	Do you bite your lips or cheeks frequently?	☐ Yes	☐ No		
15.	Have you ever had any difficult extractions?	☐ Yes	☐ No		
16.	Have you ever had any prolonged bleeding following extraction?	☐ Yes	☐ No		
17.	Do you wear dentures or partials?	☐ Yes	☐ No		

Assignment and Authorization

I hereby consent to an x-ray, laboratory procedures, anesthesia, dental or surgical treatment rendered which Falls Church Dental Care may consider or advise in the treatment of my case and guarantee payments of the charges incurred. I hereby assign and authorize payment of insurance benefits directly to Leila Saba, DDS, PC, T/A Falls Church Dental Care, and hereby authorize this dental practice to release information requested on this form. I understand that payment is due at the time service rendered, and Falls Church Dental Care will submit my insurance claims on my behalf. I understand that if there is a balance left in my account and have not been paid by due date; Falls Church Dental Care may elect to turn my account for collection. Should collection become necessary, the responsible party agrees to pay all additional collection and legal fees, including attorney fees and court cost. In addition, I understand that a minimum of 24 hour notice is required to cancel my scheduled appointment(s). I hereby authorize Falls Church Dental Care to charge my account $50 per missed appointment. Falls Church Dental Care reserves the right to inactive any patient that cancels two or more appointments.

Patients/Legal Guardian Signature: _____ Date: _____ / _____ / _____

Acknowledgement of Receipt of Notice of Privacy Practices

*you may refuse to sign this acknowledgement

I _____ have received a copy of this office's Notice of Privacy Practices.
Please print name

Signature: _____ Date: _____ / _____ / _____

▸ OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtain because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other(Please specify) _____