PATIENT INFORMATION AND HEALTH HISTORY

PATIENT INFORMATION

Last Name | First Name | MI

Address (Street) | (City, State) | (ZIP)

Home # | Work # | Cell/Pager #

Birth Date | Age | Sex ◯ M ◯ F | Soc. Sec. #

Circle One: ◯ Single ◯ Married ◯ Divorced ◯ Widow | Email

Employer Name and Address

Job Title/Occupation | Date Started

SPOUSE INFORMATION

Last Name | First Name | MI

Address (Street) | (City, State) | (ZIP)

Home # | Work # | Cell/Pager #

Birth Date | Age | Sex ◯ M ◯ F | Soc. Sec. #

Circle One: ◯ Single ◯ Married ◯ Divorced ◯ Widow | Email

Employer Name and Address

Job Title/Occupation | Date Started

Name of closest relative not living with you

Relative's address (Street) | (City, State) | (ZIP)

Relationship | Home Phone #

INSURANCE INFORMATION

Name of Insured

Employee SSN | Birth Date | Relationship

Insurance Company Name & Address

Insurance Company Phone # | Group #

Secondary Insurance Name of Insured

Employee SSN | Birth Date | Relationship

Insurance Company Name & Address

Insurance Company Phone # | Group #

ADDITIONAL INFORMATION

How did you find out about our office? | What is the reason for your visit with us today?

Are you under the care of a physician at this time? If so, what are you being treated for?

NAME OF TREATING PHYSICIAN

Have you ever been required to pre-medicate with an antibiotic prior to dental work?

Have you been hospitalized within the past year? ◯ Y ◯ N | If so, what for?

Do you use tobacco products? ◯ Y ◯ N | If so, what kind? | How often?

Women Only... Are you or could you be pregnant? ◯ Y ◯ N | If so, when is your due date?

DENTAL HISTORY

When was your last visit to a dental office? What was done?

Have you even been diagnosed with Periodontal Disease?	◯ Y ◯ N	Treatment Completed?	◯ Y ◯ N
Do your gums bleed?	◯ Y ◯ N		

Is there anything about yourself that you think we should know?

MEDICAL INFORMATION

Please check any of the following, which have had or have at present

- ☐ Abnormal Blood Pressure
- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint(s)
- ☐ Asthma
- ☐ Blood Disorders
- ☐ Blood Pressure (HIGH)
- ☐ Blood Pressure (LOW)
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chronic Cough
- ☐ Cold Sores
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ Cortisone Medication
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Drug Dependency
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Glaucoma
- ☐ Heart Disease/Attack
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A (Infectious)
- ☐ Hepatitis B (Serum)
- ☐ Herpes
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Meningitis
- ☐ Mitre' Valve Prolapse
- ☐ Organ Transplant
- ☐ Polio
- ☐ Psychiatric Treatment
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TMJ (Pain in Jaw Joints)
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ X-ray/Cobalt Treatment
- ☐ Pregnant (Women Only)

Other (Please Indicate)

Are you currently taking any medication?	◯ Y ◯ N	If so, please list:	

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:

Local Anesthetics (Novocaine/Xylocaine)	◯ Y ◯ N	Other Antibiotics Aspirin	◯ Y ◯ N
Aspirin	◯ Y ◯ N	Please List	
Sulfa Drugs	◯ Y ◯ N	Metals or Jewelry	◯ Y ◯ N
Codeine	◯ Y ◯ N	Latex	◯ Y ◯ N
Other Narcotics	◯ Y ◯ N	Other Allergies — Please List	
Please List			
Penicillin	◯ Y ◯ N		

PLEASE READ CAREFULLY AND SIGN

To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in any of this Information, / will inform the office at the next appointment. I do hereby authorise any dental service or procedure the doctor may deem necessary, for the above named patient or myseff. I also authorize the administration of those local anesthetics or pre-medications which may be deemed advisable. I will be responsible for any financial obligation for treatment for myself or for the above named patient.

Signature of Responsible Party

Date

Relationship

Staff Member Signature

Ahmed Elghobashi, D.D.D., P.C.

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

FOR OFFICE USE ONLY

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

_____

Ahmed El-Ghobashi, DDS

8350-A Traford Ln, Springfield, VA 22152 | (703) 451-1656

WRITTEN FINANCIAL POLICY

Thank you for choosing Ahmed El- Ghobashi, DDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission Is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS:

You can choose from:

- Cash, Check, Visa or Mastercard
  We offer a %5 courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of 300$ or more.

- Convenient Monthly Payment Plans' from CareCredit
  - o Allow you to pay over time
  - o No annual lees or pre-payment penalties

Please note:

Ahmed El Ghobashi requires payment prior to the completion of your treatment. If you choose to discontinue cam before treatment is complete, your refund will be determined upon review of your case.

We accept payment in thirds for treatments over $300. For larger, more comprehensive treatment plans of $500 or more, a 20% deposit is required to secure your initial treatment appointment

We also offer in-house financing for treatments over $300 that requires more than two appointments.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice,

Ahmed El- Ghobashi, DDS charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature Data

Patient Name (Please Print)

[1] *Subject to credit approval*

[2] *However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment lees and collection of your benefits directly from your insurance carrier*

Optimal Dentistry

Dr. Ahmed Elghobashi, DDS

From time to time, our office may contact you regarding any appointments and/or procedures. To help expedite this procedure, please indicate your preference for contacting you below:

PLEAE (X) BELOW TO INDICATE WHICH CONTACT YOU PREFERRED TO BE REACHED AT:

- ◯ Home Phone _____
- ◯ Cellphone _____
- ◯ E-mail _____

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS:

- ◯ Pleae DO NOT leave detailed messages for me, Only call-back instruction
- ◯ Detailed messages may be left for me on my Primary Contact

_____	_____	_____
Signed	Print Name	Date

PRINT SAVE