

Welcome to Optimum Dental
Taran Kaur, DDS
7389 Lee Highway, Suite 101
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OFFICE POLICIES:

Dr. Taran Kaur and her staff would like to welcome you to Optimum Dental. Please take a few minutes to fill out the following forms as completely as possible. If you have any questions, we will be glad to assist you. We look forward to working with you in maintaining and improving your dental health. Thank you for choosing us as your dental care provider.

APPOINTMENTS:

Our office hours are by appointment. We offer early morning and evening hours for your convenience. We ask that if you must cancel an appointment, please do so at least 48 hours in advance so that we can better manage our schedule. An appointment is a bond of trust indicating that we will be here to serve you and you will be present for your treatment. We value the time we have appointed for you and ask that you do the same. Please allot our office 48 hours notice if you are unable to make your appointment. We will be happy to reschedule for another time.

(Patients who fail to give appropriate notice may be charged a \$50 fee.)

A parent or legal guardian must accompany all minors under the age of 18 on the initial visit. On follow-up visits, written permission from parent or legal guardian the minor will be acceptable.

FINANCIAL POLICY:

We gladly accept cash, check, credit card, and most dental insurance plans. Payment for services are due in full at the time services are rendered. We understand that temporary financial problems may affect timely payment for your balance. We encourage you to notify us of any such problem so that we can assist you in the management of your account. Any outstanding balance will accrue a 1.5% interest monthly after 30 days. Delinquent accounts that are 60 days overdue will be sent to collections and assessed an additional recovery charge of the balance due.

INSURANCE:

For payment by insurance, we will gladly process your insurance claim for you as long as you provide us with the adequate carrier information. Please keep in mind that your insurance policy is a contract between you, your employer and the insurance company. We are not a party to the contract. You should address any dispute as to what should be covered by your plan to your insurance company. We will assist you in any way we can.

ATTENTION: (Patients paying with insurance)

I understand that Optimum Dental is filing my insurance as a courtesy to me. I realize that the amount I am to pay per visit is only an estimation of my percentage. In the event that my insurance denies payment or does not pay in full, I understand that I am responsible for any remaining balance. If Optimum Dental is unable to collect in payment within 90 days, I will immediately remit payment and pursue reimbursement with my insurance company.

Again, thank you for choosing us as your dental provider!

Print Name: _____ Date: _____

Patient Signature (or Legal Guardian): _____

Optimum Dental Patient Registration

Thank you for trusting us with your dental care. We strive to provide you with the finest care possible. If you have any questions or concerns at anytime during your visit, please do not hesitate to let one of us know. We will do all we can to ensure that you receive quality care and excellent service.

Patient Information:

Patient Name (Last, First M.I.): _____

Social Security #: _____ Date of birth: _____

Single _____ Married _____ Divorced _____ Separated _____ Widower _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Daytime Contact#(circle one) Home Work Cell

Email Address: _____

Employer: _____

Employer Address: _____

Emergency Contact: _____ Emergency Contact #: _____

Relationship to patient: _____

Whom may we thank for referring you? _____

Insurance Information:

Name of Dental Insurance Co.: _____

Subscriber ID or SSN#: _____

Responsible Party (If not patient):

Person Responsible for Account: _____ SSN #: _____

Relationship to patient: _____ DOB _____

Employer: _____ Work Phone #: _____

Is this your first visit to our office? (Circle Y / N)

Authorization and Release:

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to Optimum Dental, PLC or Taran Kaur, DDS, PLC benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure benefit payments on my behalf. I understand that I am financially responsible for all charges that are not paid by my insurance. Dental insurance is a contract between you, your employer, and your insurance company only. I authorize the use of this signature on all submissions.

Signature of patient, parent or guardian

Date

Dental History:

Reason for today's visit: _____

Date of last:

Dental Exam: _____ X-ray: _____ Cleaning: _____

How many times a day do you?

Floss: _____ Brush: _____ Use mouth rinse: _____

Mark (X) if you have had problems with any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Periodontal Treatment |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth or Broken Fillings |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Sensitivity to Hot/Cold |
| <input type="checkbox"/> Food Collects Between Teeth | <input type="checkbox"/> Sensitivity to Biting |
| <input type="checkbox"/> Grinding/Clinching Teeth | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Sore or Growth in your mouth |

Medical History:

Physician's Name: _____ Phone #: _____

Date of last visit: _____ Reason for visit: _____

Have you had any serious illness or operation? (Y / N)

If **YES**, describe: _____

Mark (X) if you have had problems with any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Allergy to Nickel/Other Metals | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Prosthetic Implant |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Radiat. Therapy |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respir. Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis A or B | <input type="checkbox"/> Severe Headaches |
| <input type="checkbox"/> Congenital Heart Condition | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling Feet/Ankle |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Epilepsy | | <input type="checkbox"/> Tuberculosis |
| | | <input type="checkbox"/> Ulcer |
| | | <input type="checkbox"/> Venereal Disease |

For Female Patients. Are you? Pregnant? (Y / N) (If YES, #weeks? _____)

Nursing? (Y / N)

Taking Birth Control Pills? (Y / N)

Medications currently
takeing: _____

Allergies: _____

Do you require pre-medication before dental treatment? (Y / N)
I understand and have answered the questions to the best of my knowledge.

Signature of patient, parent or guardian

Date