

Dr. Mark C. Carl, DDS

4210 Fairfax Corner West Ave.

Suite 240

Fairfax VA 22030

(703)968-4300



Patient Information

Patient Name: Last _____ First _____ MI _____ Preferred Name _____

Title _____ **Gender:** (circle) Male Female **Family Status:** (circle) Married Single Child

Birth Date: _____ **SS#** _____ **Email Address** _____

Phone: Home _____ Work _____ Ext _____ Mobile _____

Address _____

City _____ State _____ Zip _____

Date of last visit _____ **Reason** _____

Have you ever had any of the following: (Please Circle)

- AIDS Allergies Anemia Arthritis Artificial Joints Asthma
- Blood Disease Cancer Diabetes Dizziness Epilepsy Excessive Bleeding
- Fainting Glaucoma Growths Hay Fever Head Injuries Heart Disease
- Heart Murmur Hepatitis High Blood Pressure Jaundice Kidney Disease Liver Disease
- Mental Disorders Nervous Disorders Pacemaker Pregnancy Radiation Treatment Respiratory Problem
- Rheumatic Fever Rheumatism Sinus Problem Stroke Stomach Problem Tuberculosis
- Tumors Ulcers Venereal Disease

Other _____

Have you ever had complications after dental treatment: (Circle) Yes No

If yes explain _____

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Are you currently under the care of a physician: (Circle) Yes No

If yes explain _____

Do you have any other health condition that needs explaining: (Circle) Yes No

If yes explain _____

If there is ever a change please inform the doctor at the next dental appointment with out fail.

Whom may we thank for referring you to our practice? _____

Responsible Party Information:

Name: Last _____ First _____ MI _____ Preferred Name _____

Title _____ **Gender:** (circle) Male Female **Family Status:** (circle) Married Single Child

Birth Date: _____ **SS#** _____ **Email Address** _____

Phone: Home _____ Work _____ Ext _____ Mobile _____

Address _____

City _____ State _____ Zip _____

Employment Information:

The following is for (Circle) the patient responsible party

Employer Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

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Insurance Information:

Insured's Name: Last _____ First _____ MI _____

Insured's Birth Date: _____ **ID#** _____ **Group #** _____

Insured's Address _____

City _____ State _____ Zip _____

Insured's Employer Name _____

Address _____

City _____ State _____ Zip _____

Patient's relationship to insured (Circle): Self Spouse Child Other

Insurance Plan Name _____

Insurance Address _____

City _____ State _____ Zip _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption

to that our charges will be paid by an insurance company. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services **said** Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian: _____

Relationship to Patient: _____

Signature of guarantor of payment/responsible party: _____

Relationship to Patient: _____