JOHN S. K. HSU D.D.S. & VIRGINIA J. CHIN D.D.S., P.C.
10801 Main St., Ste. 500 & 600
Fairfax, VA 22030
Tel :(703) 352-2500

PATIENT INFORMATION

Name (Last)_____(First)_____(MI)____ Soc. Sec. # _____
Address_____
City_____ State_____ Zip Code_____
Sex____M____F Age_____ Birthdate_____ Occupation_____
Single____ Married____ Separated____ Divorced____ Widowed____ Home Phone #_____
E-mail Address : _____ Cellular #_____
Patient's or Parent's Employer_____
Business Address_____Business Phone _____
Whom may we thank for referring you?_____
In case of emergency who should be notified?_____Phone #_____

PRIMARY INSURANCE

person responsible for this account (Last name)_____(First)_____(MI)____
Relation to patient_____Birthdate_____Soc.Sec.#_____
Address (if different from the patient)_____Phone #_____
City_____State_____Zip Code_____
Person responsible employed by_____Occupation_____
Business Address_____Business Phone # _____
Insurance Company_____
Contract #_____Group #_____Subscriber #_____
Names of other dependents covered under this plan

ADDITIONAL INSURANCE

Is patient covered by additional insurance?_____Yes _____No
Subscriber Name_____Relation to patient_____Birthdate_____
Address (if different from the patient)_____Phone #_____
City_____State_____Zip Code_____
Subscriber Employed By_____Business Phone #_____
Insurance Company_____Soc. Sec. #_____
Contract #_____Group #_____Subscriber #_____
Names of other dependents covered under this plan_____

******* PLEASE COMPLETE BOTH SIDES *******

DENTAL HISTORY

Reason for Today's Visit_____

Former Dentist_____

Address_____

Date of last dental care_____Date of last dental X-rays_____

Check (✓) if you have had problems with any of the following:

___Bad Breath	___Grinding Teeth	___Sensitivity to hot
___Bleeding Gums	___Loose Teeth	___Sensitivity to cold or sweets
___Clicking or Popping Jaw	___Periodontal Treatment	___Sensitivity when biting

___Other things Not Listed _____

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit _____

Address_____ Phone _____

Are you presently under physicians care ? ___Yes ___No

Have you had any serious illnesses or operations ? ___Yes ___No If yes, describe _____

Have you ever had a blood transfusion ? ___Yes ___No If yes, give approximate dates_____

(Woman) Are you pregnant ?__Yes __No Nursing ? __Yes __No Taking birth control pills ? __Yes __No

Check (✓) if you have or have had any of the following :

☐ AIDS	☐ Cortisone Treatments	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis, rheumatism	☐ Cough up Blood	☐ HIV Positive	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Joints	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Fainting	☐ Liver Disease	☐ Swelling of Feet / Ankles
☐ Back Problems	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Nervous Problems	☐ Tobacco Habit
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	Describe_____	☐ Radiation Treatment	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease

☐ Other things Not Listed _____

MEDICATIONS- List medications you are currently taking

_____

_____

_____

ALLERGIES

_____

_____

_____

INSURANCE AUTHORIZATION , PAYMENT OF FEES & CONSENT FOR TREATMENT

I here by authorize **JOHN S. K. HSU D.D.S. & VIRGINIA J. CHIN D.D.S. , P.C.** to furnish information to insurance carrier concerning my treatment and hereby assign to the dentist payment for dental services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance. I authorize photographs for records and educational purposes. I authorize this office to consult with other medical / dental practitioners who I have consulted or will consult.

Payment of professional fees is expected at the time of service (cash, charge card, check) unless a specific payment plan is made by our office. Details of payment arrangements will be noted in the patients' chart.

For amount not paid at time of service, statement are mailed at the end of the month. All bills are due and payable in full on or before the **15 th** of the following month. A service charge of **1.5 % per month** will be added to the balance not paid before the next statement. The annual rate of the service charge is **18 %**. If default occurs, I agree to pay collection costs including reasonable attorney fees and interest at the rate of **1.5 % per month** on any unpaid balance.

A **service charge** will be made for appointments broken without **24 hours notice**. I give consent for the treatment provided by the Dentist to the best of his / her knowledge.

_____ _____ _____

(Date) (Patient's Signature) (Dentist' Signature)