Edward L Amos DDS, PLC, 1002 Amherst Street Winchester, VA 22601 Oral and Maxillofacial Surgery

Patient Registration Information

Name_____

Home Address _____

City _____ State _____Zip _____

Home Phone _____ Work Phone _____

Employer_____ Occupation_____

Social Security Number_____

Date of Birth _____Age _____

Name/Location of College Attending (if applicable)_____

[ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Separated [ ] Minor

Dentist/Orthodontist _____

Medical History

Are you allergic to any medications? [ ] Yes [ ] No

List the medicines you are allergic to _____

Are you taking medicines? [ ] Yes [ ] No

List the medicines you are taking _____

Circle any of the following that have occurred in your past or present medical history

Heart Problems	Shortness of Breath	Diabetes	Radiation Treatment
Bypass Surgery	Lung Problems	Bleeding Problems	Kidney Problems
Artificial Heart Valve	Anemia	Seizures	Chemotherapy
Heart Murmur	Liver Problems	Nervous Problems	Porphyria
High Blood Pressure	Asthma	Malignant Hyperthermia	AIDS/HIV
Low Blood Pressure	Artificial Joint	Ulcers	Other _____
Rheumatic Fever	Hepatitis/Jaundice	Thyroid Problems	_____
Cancer	Sickle Cell Disease	Glaucoma	**NONE**

Do you smoke? [ ] Yes [ ] No

Have you ever had problems while under general anesthesia? [ ] Yes [ ] No

Women Only: *Are you pregnant or nursing?* [ ] Yes [ ] No

Are you taking Birth Control Pills? [ ] Yes [ ] No

I hereby certify I have answered the above questions correctly.

I hereby acknowledge that I have received a copy of this practice's HIPAA Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.

_____

Signature of Patient (Parent/Guardian if patient is minor) Date

_____

Please Print Name

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Account Holder Information (If Different) *(Person responsible must be present at time of appointment)*

Name_____ Relationship _____
Home Address _____
City _____ State _____Zip _____
Home Phone _____ Work Phone _____
Social Security Number_____ Date of Birth_____
Employer_____

Insurance Information **Please Bring Cards to Front Desk to be Scanned**

MEDICAL	DENTAL
Name of Insured _____	Name of Insured _____
Relationship _____	Relationship _____
Birth Date _____	Birth Date _____
Social Security Number_____	Social Security Number_____
Insurance Company _____	Insurance Company _____
ID#_____	ID#_____
Group # _____	Group # _____
Ins. Address_____	Ins. Address_____
_____	_____

Authorization, Release and Agreement to Pay for Services Rendered.

I authorize the dentist to release any information including the diagnosis and the records of any treatment of examination rendered to me during the period of dental/surgery care to third party payers and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that my dental/medical insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Late Charges:
If you do not pay the entire new balance within 45 days of the monthly billing date, a late charge of 1.5% (18% per year) on the balance will be assessed each month.

The account is the responsibility of the patient. Accounts with balances beyond 45 days are turned over to a collection attorney (unless prior arrangements have been made with our office). In the event outside collection services are necessary, you will be responsible for attorney's fees (33.3%), court costs and interest.

Your signature acknowledges that you have read and understand the above information.

_____ _____
Signature of Patient (or Parent if patient is a minor) Date

_____
Please Print Name

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