WELCOME TO JASON D. BRANDT, D.D.S

Driver's License #:_____

Patient Information Last Name:_____ First Name:_____MI:____
❑Male ❑Female ❑Married ❑Single ❑Other:_____

Home Address:_____
(Street Address) (Apt/Suite#) (City) (State) (Zip Code)

Employer's Name:_____ Date of Birth:_____/_____/_____

Employer's Address:_____ ***Social Security#: _____-_____-_____

Name & Number & Relation of Nearest Living Relative :
_____

Home Telephone: (____)-_____-____

Work Telephone: (____)-_____-____

Whom May We Thank For Referring You To The Office?
_____

Cell/Other: (____)-_____-____

Email Address _____

Spouse Information (if applicable)
Last Name:_____ First Name:_____ MI:_____

Date of Birth: _____/_____/_____ Home Phone#: (_____)-_____-_____

Business Phone: (____)_____-_____ Employer's Name & Address: __

Responsible Party Information

Last Name:_____ First Name:_____

Relationship to Patient: ❑Parent ❑Guardian ❑Spouse ❑Other:_____ Date of Birth:____/____/____

Address (If Different From Patient):_____
(Street Address) (Apt/Suite#) (City) (State) (Zip Code)

Social Security #: _____-_____-_____ Home Phone#: (___)_____-_____

Employer's Name:_____ Cell/Other#: (___)_____-_____

Work Phone#: (___)_____-_____

Account Responsibility: The Undersigned Agrees to Pay A $35.00 Fee For Any Returned Checks. If It Should Become Necessary To Place This Account In The Hands Of An Attorney For Collection, The Undersigned Agrees To Pay An Amount Equal To One-Third Of The Unpaid Principal As An Attorney Fee, Plus All Court Costs. I Understand And Agree That The Terms Herein Are Reaffirmed Each Time Services Are Received.

X_____ _____/_____/_____
Responsible Party Signature Date

HIPAA (Health Insurance Portability and Accountability Act) **Acknowledgement of Receipt of Notice of Privacy Practices.** By signing below, the patient/responsible party certifies that they have received copy of the **Notice of Privacy Practices** for this office.

X_____ **Date:** _____/_____/_____

*****Failure to provide SSN will results in all future appointments to be paid in full before service is provided and patient is responsible to file all claims to their insurance.*****

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Medical History

Medical Doctor's Name & Phone Number: _____

Are you under a Doctor's Care now? ❑Yes ❑No If Yes, Why?_____

Have you ever been hospitalized? ❑Yes ❑No If Yes, Why?_____

Are you allergic: ❑Penicillin ❑Codeine ❑Aspirin ❑Local Injected Anesthetic ❑Latex ❑Other_____

Are you taking any Medications? ❑Yes ❑No If Yes, Please list_____

Are you pregnant? ❑Yes ❑No If Yes, What week?_____

Have you ever been told by your physician to pre-medicate before dental visits? _____

Do you smoke?❑Yes ❑No If yes, How much?___ How many years?___

Do you use any tobacco Products?_____
(Specify)

Please Check All That Apply:

❑AIDS	❑ Excessive	❑Bleeding	❑Liver Disease
❑Allergies	❑Fainting	❑Mental Disorders	❑Tuberculosis
❑Glaucoma	❑Nervous Disorders	❑Tumors	❑Anemia
❑Pacemaker	❑Ulcers	❑Arthritis	❑Hay Fever
❑Pregnancy:	❑Venereal Disease	❑Growths	❑Artificial Joints
Due date:_____	❑Head Injuries	❑Codeine Allergy	❑Asthma
❑Heart Disease	❑Radiation Treatment	❑Penicillin Allergy	❑Blood Disease
❑Heart Murmur	❑Respiratory Problems	❑Cancer	❑Hepatitis
❑Rheumatic Fever	❑Diabetes	❑High Blood Pressure	❑Rheumatism
❑Dizziness	❑Jaundice	❑Sinus Problems	❑Epilepsy
❑Kidney Disease	❑Stomach Problems	❑Stroke	OTHER:_____

Reason for this visit?:_____

Name and Address of Previous Dentist:_____
Date of Last Dental visit:_____

	Yes	NO		Yes	NO
Have you ever had a Problem with Dental Treatment?	❑	❑	Do you wear Partials or Dentures?	❑	❑
Do your gums bleed easily?	❑	❑	Have you ever had gum surgery?	❑	❑
Do you gag easily?	❑	❑	Are you happy with your smile?	❑	❑
			Do you clench or grind your teeth?	❑	❑

Printed Name (Patient) Signature (Parent or Guardian) Date

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INSURANCE INFORMATION

Patient's Name:

_____

Primary Insurance Information	
Name of Insured:_____ **Insured Social Security#_____** **Insured ID #_____** **Insured Date of Birth:_____** **Effective Date of Policy:_____**	**Employer:_____** **Insurance Company:_____** **Group #_____** **Group Cov____ Single Cov___**
Relationship of patient to the insured ❑Self ❑Spouse ❑Child ❑Other_____ **(specify)**	
Mail Claims to:_____ **_____**	

Secondary Insurance Information	
Name of Insured:_____ **Insured Social Security#_____** **Insured ID #_____** **Insured Date of Birth:_____** **Effective Date of Policy:_____**	**Employer:_____** **Insurance Company:_____** **Group #_____** **Group Cov_____ Single Cov_____**
Relationship of Patient to the insured ❑Self ❑Spouse ❑Child ❑Other_____ **(specify)**	
Mail Claims to:_____ **_____**	

Insurance filing is a courtesy provided to our patients and is in no way a responsibility of the office. We must have the correct information as well as your signature on file at the time of the service. If not, you will need to file your own claims.

*I hereby authorize payment of benefits directly to **JASON D. BRANDT DDS.** I understand that I am responsible for charges not covered by my carrier. A photocopy of this authorization shall be considered as valid as the original.*

_____ _____

Patient or Parent/Legal Guardian Signature Date

WELCOME TO JASON D. BRANDT, D.D.S

13663 0FFICE PLACE, SUITE 103
WOODBRIDGE, VA 22192
703-878-2100
brandt@mydentistwoodbridge.com

Dental Insurance and Billing

If you have insurance through your employer, and you are the policy holder, (the insurance is in your name) this insurance will be primary for you, and your spouse's insurance policy will be secondary. The insurance policy through your spouse's employer would be their primary and your policy would be their secondary.

Children that are covered by two insurance plans generally fall under the "birthday rule" if there are two plans. Under this rule, the plan of the parent whose birthday occurs first in the calendar year is designated as primary. The date of the birth is the determining factor--not the year--so it doesn't matter which spouse is older.

UCR's (usual and customary rates) are applicable only to plans with which we participate (i.e. Delta Dental Premiere, Cigna, GEHA-Connection Dental Plans, United Healthcare).
Once your insurance has paid their amount, any remaining

Returned Checks
A fee in the amount of $35.00 will be charged for all returned and "insufficient fund" checks.

All claims will be submitted to insurance for payment. Any remaining amount not paid by insurance is your responsibility. Once all payments are received from your insurance, if there is a remaining balance, that balance is due and immediately invoiced to you. If this balance is unpaid, it will be transferred to a collections department and no longer billed through this office.

_____ _____ _____

Signature of Responsible Party **Print Name** **Date**

WELCOME TO JASON D. BRANDT, D.D.S

Appointment Cancellation Policy

We strive to provide excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. Your appointment time is scheduled specifically for you and your treatment. In order to provide excellent care, it is our office's policy to schedule **one** patient at a time. When the appointment is missed, or we are given less than 48 hours notice, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **48 hours notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, or give less than 48 hours notice, this is considered a missed appointment. A fee of $75-$150 will be charged to you depending on the length of your appointment; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than **20 minutes late** for a scheduled appointment, we will consider this a missed appointment and the $75 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I,_____(print name), have received a copy of Dr. Jason Brandt D.D.S Appointment Cancellation Policy.

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Signature of Patient Date