welcome

FARHAN M. QURESHI, DDS, PC
COSMETIC, FAMILY &
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PH. 703.931.4544

5206 DAWES AVENUE
ALEXANDRIA, VA 22311

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form.
If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Date _____

Name (Full) _____ Preferred Name _____ Soc. Sec. # _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced Birthdate _____ ☐ Male ☐ Female

If Student, Name of School / College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____

City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____

Max. Annual Benefit _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you wearing contact lenses?	☐	☐

7. Do you have or have you had any of the following?

	Yes	No
AIDS or HIV Infection	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis	☐	☐
Aspirin Therapy	☐	☐
Asthma	☐	☐
Bisphosphonate (Fosamax)	☐	☐
Blood Thinners	☐	☐
Cancer	☐	☐
Cardiac Pacemaker	☐	☐
Chest Pains	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy / Convulsions	☐	☐
Fainting / Seizures	☐	☐
Glaucoma	☐	☐
Hay Fever / Allergies	☐	☐
Heart Attack	☐	☐
Heart Disease	☐	☐
Heart Murmur	☐	☐
Heart Trouble	☐	☐
Hepatitis / Jaundice	☐	☐
High Blood Pressure	☐	☐
Joint Replacement or Implant	☐	☐
Kidney Diseases	☐	☐
Leukemia	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
Organ Transplant	☐	☐
Radiation Therapy	☐	☐
Recent Weight Loss	☐	☐
Respiratory Problems	☐	☐
Rheumatic Fever	☐	☐
Sexually Transmitted Disease	☐	☐
Sleep Disorders/Apnea	☐	☐
Stomach Troubles / Ulcers	☐	☐
Stroke	☐	☐
Swollen Ankles	☐	☐
Thyroid Problems	☐	☐
Tuberculosis	☐	☐
Other _____	☐	☐

	Yes	No
8. Are you allergic to or have you had any reactions to the following?		
Local Anesthetic (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
9. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you had dry mouth?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent if minor)

Agreement for Extension of Credit

In accordance with the Federal Truth-In-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in this office. The responsible party agrees to:

1. *Pay the doctor at the time treatment or service is received or by previous arrangements.*
2. *That if payments are extended beyond 60 days from the date of first billing to pay 1% per month on the unpaid balance (annual rate of 12%) with a minimum charge of $1.00 per month.*

I/We agree to pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.

Date _____ Signature _____