Ihab Abboud, DDS
Leesburg Bright Dental

EXISTING PATIENTS

Please update the following information for you or your child. Thank you!

Patient's Name: _____
Parent/Guardian's Name: _____
Address: _____
Home Phone #: _____ Preferred Cell Phone #: _____ Work # _____

Preferred Email: _____

Please check if you would like to **OPT OUT** (Not Receive) of reminders by _____Email or _____ Text

Dental Insurance Company: _____ Employer: _____

Is this new insurance? _____ Yes or _____ No Subscriber's Name: _____

Have you or your child (whomever is being seen today) been diagnosed or treated for any of the following conditions? Please check all that apply.

_____ADD/ADHD	_____Asthma/breathing problem	_____Autism Spectrum
_____Bleeding problems	_____Cancer/leukemia	_____Diabetes
_____Heart disease/murmur	_____Hepatitis/liver disease	_____HIV infection/AIDS
_____High Blood Pressure	_____Kidney disease	_____Rheumatic/scarlet fever
_____ Seizures	_____Sickle Cell Trait	_____Syndrome: Type_____
_____Tuberculosis	_____Other_____	Hospitalization_____

Medications: _____

Allergies: _____

Financial Consent

Initial _____ I acknowledge that I have read and agree with the office financial policy. ***I understand that any estimate of my insurance benefits is solely an estimate and not guarantee of payment.*** I understand this office bills my insurance as a courtesy and is not required to file my claims either legally or contractually. I am ultimately responsible for knowing the benefits and limitations of my plan. I understand this office only places composite (tooth-colored) fillings and I may have a higher copay if my insurance only covers amalgam (silver) fillings for back teeth. I also understand other charges such as, but not limited to, nitrous oxide (laughing gas), infection control, and fluoride may not be covered by insurance and will be my financial responsibility.

Initial _____ I certify that I have given the correct insurance information to the office and will notify the office of any changes in the insurance company or coverage. I also understand that fees and treatment needs are subject to change and previous estimates are not to be considered a guarantee.

Initial _____ I acknowledge that payment in full is expected in cases of no insurance unless extended financing has been obtained.

Initial _____ I agree that balances over 45 days after the appointment date will be applied to my credit card and that I will be responsible for obtaining insurance reimbursement for any outstanding claims. I understand that I will be responsible for legal or collection fees if my account becomes overdue. I understand that a 48 hour notice is required to cancel or reschedule an appointment to avoid a $75-$150/per hour cancellation fee. Repeated missed appointments may result in termination of the doctor-patient relationship. This consent will remain in effect unless cancelled in writing.

Signature _____ **Print Name** _____

Relationship to Patient _____ **Date** _____