Ihab Abboud, DDS
Leesburg Bright Family Dentistry

PATIENT REGISTRATION & MEDICAL/DENTAL HISTORY

Please complete ALL information requested and print clearly so we can enter your information accurately in our system.

PATIENT INFORMATION

Last_____________________________ First_________________________ Middle________________________
Date of Birth ______________________ Sex: Male____ Female____ Marital Status _______________
Social Security #______________________ If minor, parent/guardian name: ______________________________
Street Address ____ Apt#______
City _________________________ State ______ Zip ____________
Cell#____________________ Home # _____________________ Email _________________________________
Occupation ______________________ Employer ________________________ Work # ___________________

Reason for visit ____
Whom may we thank for your referral? ___________________________

As a courtesy, we will remind you of every appointment you have reserved with our office. Please circle which method of contact you prefer to receive your reminder.

Phone Call/Voicemail **Text** **Email**

RESPONSIBLE PARTY INFORMATION

Last_____________________________ First_________________________ Middle________________________
Relationship to patient______________________________ Social Security #_____________________________
Sex: Male_____ Female_____ Marital Status ________________ Date of Birth__________________________
Street Address (if different than above) ____ Apt#______
City _________________________ State ______ Zip ______________ E-mail ______________________________
Cell#________________________ Home# ___________________________ Work#_______________________

DENTAL INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Insurance Company ___________________________	Insurance Company ______________________________
Insured Name_________________________________	Insured Name __________________________________
Date of Birth_________________________________	Date of Birth ___________________________________
Employer____________________________________	Employer _____________________________________

PATIENT TREATMENT CONSENT

I authorize the dentist or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis. I authorize the dentist to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the dentist and mutually agreed upon by me. I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy to the dentist. This form also authorizes the practice to submit claim treatment forms and receive payment directly from the insurance carrier with the notation "SIGNATURE ON FILE." I authorize my dentist to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary or requested. I agree to be responsible for payment of all services rendered on my behalf and my dependents. I agree that I am responsible for any unpaid claims.

Patient or Parent/Guardian Signature_______________________________ **Date** _____________________________
Relationship to Patient ____

2/22/2017