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PATIENT INFORMATION

(This information is necessary for our files and is strictly confidential)

Patient's Last Name: First Name: Middle:

Home Phone: Cell Phone: Fax:

Email Address: Do you check it regularly ? ☐ Yes ☐ No

Home Address: Street City VA State Zip Code

Date of Birth: Social Security Number: Driver's Licence #:

If a student, name of school: Whom may we thank for referring you?

Place of Employment: Employer's Address:

Occupation: Work Phone:

In case of emergency who should be notified? Phone Number:

FINANCIAL INFORMATION

Name of Person Responsible for this Account: Relationship:

Street Address: Street City VA State Zip Code

Social Security Number: Date of Birth

Place of Employment: Work Phone:

Employer's Address:

Is this person currently a patient at our office ? ☐ Yes ☐ No

DENTAL INSURANCE

Insured Person's Full Name: Date of Birth:

Social Security Number: Relationship to Patient:

Insurance Company Name: Group ID Number:

Insurance Company Mailing Address for Dental Claims:

Employer Name: Is there dual coverage for dental claims? ☐ Yes ☐ No

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Appointment No Show and Cancellation Policy

Patients who need to cancel their appointment, should do so by calling Lee Plaza Dental at least 24 hours in advance of their scheduled appointment. "No shows" and "Late Cancellations" waste the Dr.'s and staff's time and adversely affect the care provided to our patients. **All "no shows" and late cancellations will be billed $50.00**

Assignment and Release of Insurance Benefits

In consideration of services rendered, I hereby transfer and assign to Lee Plaza Dental, 11725 Lee Highway Suite A23, Fairfax, Virginia, right, title and interest in any payment due for services as provided in the policy or policies of dental insurance held by me.

I agree to pay the charges of Lee Plaza Dental, which exceed the amount paid by the insurance policies held by me. I further agree and authorize Lee Plaza Dental, to release any information requested by the insurance company(s) or its representatives. I understand that filing of my dental insurance is done as a courtesy to me.

Authorization for Treatment

I hereby authorize Lee Plaza Dental, to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient named below and further authorize and consent that Dr. Amanda Yeun-Hee Yi chooses and employs such assistance as she deems fit. I also understand that prior to treatment; full explanation of the procedure(s) involved will be given by Dr. Yi and /or her staff. I further authorize the use of any study models, photographs or radiographs taken by Dr. Yi to be used by him for educational or teaching purposes.

Agreement to Pay for Services Rendered

I agree to pay for all services rendered by Dr. Amanda Yeun-Hee Yi. I further understand that I am legally responsible for all cost of treatment, regardless of any estimated insurance balance. I also understand and agree that any and all past due balances over thirty (30) days will be subject to a finance charge of 1.5% (18% annually) per month, as allowed by the laws of the State of Virginia.

Name of Patient:

Signature Field: Date: