



Midlothian Family Dentistry

14420 Sommerville Ct
Midlothian, VA 23113
(804)897-7900

WELCOME TO OUR PRACTICE. Our goal is to help you reach and maintain maximum oral health. Please fill out this chart completely. The better we communicate, the better we can care for you.

Today's date: _____ Whom may we thank for referring you? _____

Name: _____ I prefer to be called: _____

MR MRS MS DR FIRST M. Last
_Single _Married _Divorced _Widowed M or F _____ Birth-date _____ - _____ - _____ SSN #: _____

Home address: _____
Street City State Zip

Home #: _____ Cell #: _____ Work #: _____ Ext.: _____

Email address: _____@_____

Do we see other family members? _____

Employer: _____ Occupation: _____

Address: _____

Spouse Name: _____ Birth-date: _____ SSN# _____

Employer: _____ Work #: _____ Ext.: _____

In the event of an emergency, is there someone whom we should contact other than your spouse?

Name: _____ Relation: _____ Home #: _____ Other #: _____

DENTAL INSURANCE: Policyholder name: _____ Birth-date: _____

SSN#: _____ Relationship to patient: _____ Employer: _____

Ins. Co. Name: _____ Phone #: _____ Group #: _____

Ins. Co. Address: _____
Street or PO Box # City State Zip

If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage your program provides. We accept assignment of most insurance companies. This means that you are responsible for your deductible and the portion the insurance does not cover at the time service is provided. *Remember however, you are responsible for the total treatment fee regardless of what we might calculate as your portion, if for any reason the insurance does not honor their commitment to you or us.*

CONTRACTUAL AGREEMENT:

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW

I understand all patient portions are due payable at the time services are rendered.

I authorize payment directly to Midlothian Family Dentistry for the benefit otherwise payable to me under the terms of any insurance. I understand I am financially responsible for all charges arising from the treatment of the below-named patient and any insurance payments will be credited to the account.

In the event the bank returns any check given in payment on this account unpaid for any reason, a \$30.00 charge will be added to the account balance each time such a check is returned.

If all charges are not paid in full within sixty (60) days from the date of service I agree to pay the service charge of 1.8% per month, twenty-one (21%) per annum, interest on the unpaid balance, along with a \$5.00 late charge.

If this account is referred to an attorney for collection, I agree to pay all costs of collection, including, but not limited to, an additional thirty-three and one-third of total balance owed for attorney's fees, in addition to all court costs.

I understand, in accordance with Section 32.1-45.1 of the Code of Virginia, 1950, as amended, that if the provision health care services to the patient at this office directly exposes any person by or under the direction and control of the health care provider to the patient's body fluids in a manner which may transmit immunodeficiency virus or HIV, then the patient shall be deemed to have consented to testing for infection with HIV and to the release of such tests results to the persons exposed.

I further understand that I will be charged a minimum fee of \$50 per one-half (1/2) hour for all missed or cancelled appointments unless forty-eight hour notice is given.

Name: _____ Relationship to patient: _____

SIGNATURE: _____ Date: _____ Witness: _____

R. A. Sorenson & Associate

Employee

