Christian S. Tabor DMD, PC

12000 Wyndham Lake Drive
Suite A
Glen Allen, VA 23059
804.364.7122
Facsimile 804.364.8898
www.westendteeth.com

Thank you for choosing Dr. Christian Tabor for your Family Dental Care. We appreciate the trust you have placed in us and will make every attempt to honor that trust by providing the quality of dental care you require and deserve. We will do everything possible to make your visit to our office pleasant.

Our office hours are Monday and Friday 8:00-5:00, Wednesday 8:00-1:00, and Tuesday and Thursday 9:00 to 6:00

For your first appointment, please arrive 15 minutes early so that we will be able to prepare your file. OR you may fax us your paperwork at (804)364-8898. We make every effort to be on time for our patients and ask that you extend the same courtesy to us. If you cannot keep an appointment, please notify the office immediately. If possible, please give us 24 hours notice. This courtesy on your part will make it possible for us to give the appointment to another patient who needs to see us. For cancellation of appointments *without a 24 hour notice*, patient will be assessed a $50 cancellation fee.

Enclosed, please find the paperwork that we need for your file, which includes general information as well as the *Notice of Privacy Practices*, please read and sign the receipt of acknowledgement form, Health Information Page, there are (3) Signatures we need on this form. The *Notice of Privacy Practices* is a copy for you to keep. We will also need you to please bring with you, your insurance card.

Our practice is dedicated to the quality care and exceptional service. We respect the importance of your time, and work very hard to schedule appointments that accommodate the busy scheduling needs of our patients. In return, we ask that all patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients and for our office. If you must change a scheduled appointment we require a minimum of 24-hour notice so that we may accommodate another patient. A charge will be applied for broken and missed appointments without advance notification. Thank you for your cooperation on this matter.

Thank you again for choosing Dr. Christian Tabor as your Dental Provider. Please feel free to check out our website www.westendteeth.com.

We look forward to having you and your family as new patients.

Sincerely,

Dr. Tabor and his Team

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell Phone):_____

E-Mail Address: _____

Address: _____
Street Apartment #

_____ _____
City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell Phone): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Subscriber's Insurance Information

Primary

Name of Subscriber: _____ Is Subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____/____/_____ ID #: _____ Group #:_____

Subscriber's Address:_____

If not same as above

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Health Information

*****Please list ANY medications you are currently taking:**_____
_____
_____

Date of Last Dental Visit: _____ Reason for today's visit:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ **Allergies to any Medications?**
_____
_____
_____
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____
☐_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

  If yes, please explain:_____

- Are you now under the care of a physician? ☐ Yes ☐ No

  If yes, please explain:_____

- Name of Physician: _____ Phone:_____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail. I understand the importance of my health history and affirm that I have given any and all information that may impact my care. I understand that failure to give true health information may adversely affect my care and lead to unwanted complications.

_____ Date:_____
Signature of patient, parent or guardian if Patient is a Minor

Payment Agreement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. For cancellation of appointments *without a 24 hour notice*, patient will be assessed a $50 cancellation fee.

Patients who carry dental insurance understand that all dental services furnished are filed directly to the insurance carrier BUT patient; he or she is personally responsible for payment of all dental services. This office will file all treatment with patient's insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. It is the responsibility of the patient to cover all co-pays, deductibles and balance not paid by insurance carrier.

A Treatment plan may be drawn up to show patient an "estimate" of fees and insurance payments, but those are just an estimate of what we expect the insurance to pay, Patient is responsible for any fees not paid by insurance including deductible if applied.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of payment and agree to their content.

_____ **Date:** _____ **Relationship to Patient:** _____

Signature of Guarantor of Payment /Responsible Party

Consent for Services

In General, there are certain risks associated with having dental procedures performed. Sore gums or teeth are common following dental treatment and other risks exist as well. For example, bruising from having injections, inflamed areas, small or large swellings – either inside the mouth or outside on the lips and cheeks. Even instances of parasthesia can occur – a temporary or permanent numbness following injections and or extraction of teeth. These instances are rare, but can occur due to anatomical differences from person to person. Should any of these occur following treatment please inform our staff so we can render treatment needed to help the outcome. I certify that I speak, read and write English and have read fully and understand this consent for treatment, have had any questions answered and that all blanks were filled in prior to my initials or signature.

I have read the above conditions of treatment and agree to their content.

_____ **Date:** _____ **Relationship to Patient**_____

Signature of patient, parent or guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I certify that I have received a copy of this office's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Christian S. Tabor DMD, PC.

_____
Please Print Name of Patient or Personal Representative

_____
Signature of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

Other ☐ (Please specify)

_____

_____

_____

_____

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Credit Card Authorization

The Office of Christian S. Tabor, DMD, P.C., has my permission to charge my credit card on file for any charges not paid by my insurance company or for services rendered on my behalf.

I understand that if any charges are put on to my card, I will be notified with a statement along with Credit Card Receipt from Dr. Tabor's office, via mail.

This is optional and NOT required for treatment to be rendered at Dr. Tabor's Office.

Patient _____ Date___/___/___

Printed Name_____

Card Type: American Express Master Card Visa

Card Number:_____ Expiration Date:___/___ Security Code:_____