

Central Virginia Dental Care, PLC.

DAVID CIRCEO, DDS

ZAID ALSAMIR, DDS

6113 LAKESIDE AVENUE, RICHMOND, VA 23228

804-262-9824

PATIENT INFORMATION

Name _____ Preferred Name _____

Address _____

City, State Zip _____

Phone Home _____ Work _____

Cell _____

Male/Female _____ Marital status _____ Date of Birth _____

Social Security # _____

E-mail _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship to Patient _____

Address _____

City State, Zip _____

Phone Home _____ Work _____

Cell _____

Male/Female _____ Marital status _____ Date of Birth _____

Social Security # _____

DENTAL INSURANCE INFORMATION

Name of Subscriber _____ Date of Birth _____

Subscriber ID# _____

Insurance Co. Name _____ Insurance Co Phone # _____

Employer _____ Group # _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Subscriber _____

Subscriber ID# _____

Insurance Co. Name _____ Insurance Co Ph # _____

Employer _____ Group # _____

Whom may we thank for referring you? _____

Central Virginia Dental Care, PLC.

David Circeo, DDS

Zaid Alsamir, DDS

INSURANCE AUTHORIZATION, ASSIGNMENT AND RELEASE

I certify all information provided is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance to release the assignment of benefits directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

We are glad to assist you in securing payment of claims, but ask that you pay your estimated portion when services are rendered. In fairness to the dentist, patients must understand insurance is a contract between the patient and the insurance company.

Payment of professional fees is due in full, unless arrangements are approved prior to treatment.

We accept Cash, Checks, Money Orders, Mastercard, Visa, Discover, American Express and Care Credit.

As a service to our patients who are covered by insurance, the office can assist in filing the insurance claim. Any co-payments, however, are due when services are rendered.

The fee for a returned check is \$35.00.

We reserve the right to charge a \$35 missed-appointment fee **per** appointment time if appointment is broken or cancelled with less than a 24-hour notice.

I agree to be responsible for payment of all services rendered on behalf of my dependents and myself. I agree to pay all costs of collections including 33 1/3% collections/attorney's fees if I default.

Signature _____ Date _____
Patient (or) Parent/Responsible Party (if a minor)