JOHN H. SATTAR, DDS
FAMILY DENTISTRY

Patient Information

Date: ______________________
First Name: ______________________
Date of Birth: ______________________
SSN: ______________________
Address: ______________________
____
Cell Phone: ______________________
Email: ______________________
SEX : F ☐ M ☐
Marital Status : ______________________
Employer: ______________________
Address: ______________________
Occupation:______________________
Referred by : ______________________

Responsible Party Information

Full Name: ______________________
Relationship to Patient: ______________________
Date of Birth: ______________________
SSN: ______________________
Address: ______________________
____
Phone: ______________________
Email: ______________________

In Case of Emergency , Notify :

Name: ______________________
Cell Phone: ______________________
Email: ______________________

INSURANCE AND PAYMENT INFORMATION

Please provide us the copy of your ID and your dental insurance card (s).

Primary Dental Insurance Co: ______________________ ID#: ______________________

Secondary Insurance Co: ______________________ ID#: ______________________

Form of Payment : ☐ Cash ☐ Check ☐ Visa/MC

PLEASE READ AND SIGN

Appointment Policy: There will be a $25 charge for appointment cancelation or no show.

Financial Authorization: I understand that I am financially responsible to Dr. John Sattar for the charge incurred by myself and/or my dependents. I agree that in the event my account is past due for 60 days from the date of service, it is turned over to an attorney for collection and I will also be liable for attorney's fee in the amount of 1/3 of the Principle balance, plus all court costs. I will pay interest on accounts past due 45 days or more at the rate of 1.5% per month (18% annually).

Signature: ______________________ Date: ______________________

Dental/ Medical Insurance Authorization: I hearby assign all Medical, Dental and/or surgical benefits to which I am entitled for this service to Dr. John Sattar. This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize assigns to release all information necessary to secure payments.

Signature: ______________________ Date: ______________________

Dr. Sattar Dental and Medi Spa
20 Pidgeon Hill Drive Suite 105, Sterling, VA 20165
703-450-9723
www.drsattardentalspa.com