Joseph P. Cavallo, D.D.S. MAGD
12502A Lake Ridge Drive
Woodbridge, VA 22192
703-490-5888
Patient Information/Confidential

Patient Name_____
First Name Middle Name Last Name Nick Name
Address_____
Street & Number City State Zip` `
Home Phone: ( )____-_____ Cell Phone: ( )____-_____ Work Phone: ( )____-_____
E-mail address:_____@____._____
Gender: M F Age:_____Birthdate:____/___/_____ SSN or DL#_____
Single Married Widowed Partnered Divorced
Is Patient a minor? Yes* No *If yes, please complete section below with Parent/Guardian Information

Patient's Employer:_____Occupation:_____

How did you hear about us?
___Referral ___Website ___Google ____Facebook___Instagram Other_____

WHOM MAY WE THANK FOR REFERRING YOU?
___Westminster ___ Patient Name:_____

Emergency Contact:_____Phone ( )____-_____ Relation to Patient_____

Parent/Guardian Information:
Mother_____ DOB_____ SSN or DL#_____
Employer_____ Occupation_____ Work Phone: ( )____-_____

Dental Services Contract Terms and Conditions: (please read and sign)
A standard of excellence in personalized dental care enables our office to provide the quality dental services our patients deserve. We provide comprehensive treatment planning and use preventive, restorative and cosmetic dentistry to achieve your optimal dental health. In consideration for the professional service to be rendered to me, by Joseph .P Cavallo, DDS, MAGD, (hereinafter referred to as the "Doctor*) , the patient accepts the service and hereby agrees to pay for the fees charged for said services by the Doctor, at the time said services are rendered. As a condition of treatment by the Doctor, any financial arrangements/agreements must be made in advance and prior to starting treatment. If, I, the patient, have dental insurance, I understand this Doctor is considered a **NON-PARTICIPATING PROVIDER** with all insurance companies and plans. I understand I am responsible for knowing what my plan benefits and limitations are. The Doctor's office will prepare and submit the insurance forms if all information is given correctly prior to treatment for predetermination. I am responsible for paying my share of cost according to my benefits at time of service. If benefits cannot be determined for any reason, I am responsible for the full fee at the time of service. I, the patient understands that limitations in my coverage or payment by my insurance company does not limit my liability to the treating doctor. If any charges remain unpaid on my account after 30 days from the date of the original statement, I hereby agree to pay the **18% APR** each month on the unpaid balance. A $30 bank fee is accrued on accounts for returned checks. In the unlikely event my account is placed for overdue collections or small claims. I, the patient, agrees to pay all court costs and expenses incurred on my behalf for the full collection of the account.

Signature_____ Date_____

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Patient Insurance Information/Confidential

Patient Insurance Information:

Subscriber/Insured Person:_____Subscriber DOB:_____

Relationship to Patient:_____Insured's SS#:_____

Insurance Name:_____Subscriber/Member#:_____

Claims Address:_____Group Name and #_____
Street Address

_____
City State Zip

I am aware of this office, and Dr. Joseph P. Cavallo, D.D.S., MAGD., is considered a **NON PARTICIPATING PROVIDER** with **ALL** insurance companies. I understand insurance may be filed on my behalf as a courtesy. I understand that I have a contract with my insurance carrier and I am responsible for knowing what my plan benefits and limitations are. I am aware that reimbursements for treatment will be made at the plan's allowable rate or on the Doctor's UCR fees per my insurance.

Signature_____Date_____

I understand there can be no guarantee of payment by an insurance plan, and that coverage is estimated. The office will send a pre-treatment claim to my insurance company for an estimated predetermination of benefits on my behalf prior to starting treatment. I am aware the office can make no guarantee of any insurance payments for any dental service. I accept full responsibility for payment that may not be covered by my insurance carrier when services are rendered. I understand that any remaining balance after my insurance makes payment is my responsibility. Any services not paid for my insurance within 45 days will become my responsibility. I understand that I am financially obligated to pay the office for all charges whether or not paid by my insurance.

Signature_____Date_____

Insurance Authorization for Direct Assignment and Designation of Authorized Representative:
If applicable, I authorize my insurance company to pay Joseph P. Cavallo, D.D.S., MAGD all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions by Joseph P. Cavallo, D.D.S.,MAGD to act as my authorized representative in requesting (check all that apply) _____a complaint_____an appeal_____documents from my insurance company for any service or proposed service. I authorized the office to release all information necessary to secure the payment of benefits on my behalf.

Signature_____Date_____

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Financial Policy/Confidential

Financial Policy

Thank you for choosing this office for your Dental Care needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

Our self-pay patients are required to PAY IN FULL AT TIME OF SERVICE.

We accept and will file your insurance on your behalf as an **OUT OF NETWORK** provider with all insurance plans. Any services not covered or portions of will be the patient's responsibility. Your insurance is a contract between you and your insurance company. We are not a party to that contract.

Patient is responsible for providing this office with the up to date insurance information in order for us to file your claim. Payment is considered past due 45 days after insurance has addressed the claim. If insurance has not addressed your claim after 30 days we will reprocess the claim. If we get no response from the insurance company, the balance will then become the responsibility of the patient.

Our practice is committed to providing the best treatment for our patient and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We reserve the right to charge interest on delinquent accounts as provided by state law. I have read and understand the financial policy and agree to abide by this policy.

Signature of Patient or Responsible Party_____Date_____

Joseph P. Cavallo, D.D.S. MAGD
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Appointment Agreement/Confidential

Appointment Agreement

Dr. Joseph P. Cavallo, D.D.S., MAGD, understands that your time is very valuable. We are constantly striving to make your experience a pleasant one. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointments are commitments of time between you and our office. In order to make sure you are well cared for we reserve the time especially for you. Because of this we ask that you make every effort to keep your appointments.

We do provide a courtesy reminder email and phone call one week, 3 days and 1 day prior to your appointment until the appointment has been confirmed by you. However, if you find that you cannot keep your appointment, we do require **24 hour advance** notice so we are able to make arrangements to help other patients during that time.

We truly appreciate your understanding. Dr. Cavallo's goal is to be your partner in health and to assist you in keeping your teeth for a lifetime.

By signing below, I acknowledge that I have read the above terms and understand the importance of keeping the appointments that I reserve. In the event that I should need to reschedule, I agree to provide Dr. Cavallo's office with proper notice so that other patients may be cared for.

Signature of Patient_____Date_____

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Release for Dental CT-SCAN and X-Rays/Confidential

Release for Dental CT-SCAN and X-Rays

I understand that all **X-RAYS** and **CT-SCANS** are part of the original dental records included in the free consultation, and belong to **Joseph Cavallo, D.D.S., MAGD.**If I want a copy of my **X-RAYS** or **CT-SCANS,** or if the **RADIOGRAPHS** are requested by another dental office, **NOT REFERRED BY DR. CAVALLO,** I have been made aware of the fees and I will need to provide payment **PRIOR** to the **RADIOGRAPHS** or **SCAN(S)** being sent to the new dentist or myself.

INTRAORAL PERIAPICAL-1ST RADIOGRAPH: $47.00

INTRAORAL PERIAPICAL-EACH ADD'L RADIOGRAPH: $40.00

FULL MOUTH SERIES: $200.00

CT SCAN: $262.00 PER ARCH OR $367.00 FOR BOTH JAWS

PATIENT SIGNATURE:_____DATE_____

MEDICAL HISTORY

PATIENT NAME_____

PATIENT ACCOUNT NO._____MEDICAL ALERT_____

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If Yes, for what? _____
   Physician's Name_____ _____Phone ( )____-_____
   Address_____City_____State_____Zip_____

2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medication, drugs or pills now?_____ Yes No
   If Yes, please list name and dosage: _____
   _____
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No
   If Yes, please list:_____

5. Have you been a patient in the hospital during the past five years? Yes No
6. Do you use more than two pillows to sleep?
7. Have you lost or gained more than 10 pounds in the last year?
8. Do you have or have you had any disease, condition, or problem not listed?
9. Women. Are you: Pregnant? Yes, _____Months No Nursing Yes No Taking Birth Control Pills Yes No
   a. If yes, please list_____

10.. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item?

Heart (Surgery, Disease, Attack).. Yes No
Chest Pain……Yes No
Congenital Heart Disease…….. Yes No
Heart Murmur …….. Yes No
High Blood Pressure……Yes No
Mitral Valve Prolapse……...Yes No
Artificial Heart Valve ……Yes No
Heart Pacemaker ……Yes No
Rheumatic Fever……..Yes No
Arthritis Rheumatism…….. Yes No
Cortisone Medicine……..Yes No
Swollen Ankles…… Yes No
Stroke ……...Yes No
Diet (Special, Restricted).....Yes No
Artificial Joints(hip, knee, etc.).....Yes No
Kidney Trouble……Yes No

Bruise Easily……..Yes No
Liver Disease……Yes No
Yellow Jaundice……Yes No
Neurological Disorders……Yes No
Epilepsy or Seizures……Yes No
Fainting or Dizzy Spells……Yes No
Nervous/Anxious ……..Yes No
Psychiatric/Psychological Care ……..Yes No

Ulcers…….. ….Yes No
Diabetes……Yes No
Thyroid Problems ……Yes No
Glaucoma……..Yes No
Contact Lenses…….Yes No
Emphysema……...Yes No
Chronic Cough……..Yes No
Tuberculosis……...Yes No
Asthma……Yes No
Hay Fever……..Yes No
Latex Sensitivity……Yes No
Allergies or Hives…….Yes No
Sinus Trouble……Yes No
Radiation Therapy……Yes No
Chemotherapy……..Yes No
Tumors……Yes No

Hepatitis A (infectious) B (serum).....Yes No
Venereal Disease……..Yes No
A.I.D.S ……Yes No
H.I.V Positive ……Yes No
Cold Sores/Fever Blisters……Yes No
Blood Transfusion ……Yes No
Hemophilia……Yes No
Sickle Cell Disease……...Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature_____Date_____

History Review

Doctor Signature_____Date_____

_____

Dental History

Patient Name

_____

Patient Account Number Medical Alert

_____

What is the reason for your visit today?_____

_____

Date of Last Dental Visit_____Last Dental Cleaning_____Last Full Mouth X-Rays_____
What was done at your last dental visit?_____
_____
Previous Dentist's Name_____
Address_____State_____Zip_____
Telephone_____

How often do you have dental examinations?_____
How often do you brush your teeth?_____How often do you floss?_____
What other dental aids do you use? (interplak, toothpick, etc.)_____

Do you have any dental problems now? Yes No
If yes, please describe:_____

Are any of your teeth sensitive to:
- Hot or Cold?
- Sweets?
- Biting or Chewing?
- Have you noticed any mouth odors or bad tastes?
- Do you frequently get cold sores, blisters or any other oral lesions?

Do your gums bleed or hurt?
- Have your parents experienced gum disease or tooth loss?
- Have you noticed any loose teeth or change in your bite?
- Does food tend to become caught in between your teeth?
  - If yes, where?_____

Do you:
- Clench or grind your teeth while awake or asleep?
- Bite your lips or cheeks regularly?
- Hold foreign objects with your teeth?
  - (pencils, pipe, pins, nails, fingernails)
- Mouth breath while awake or asleep?
- Have tired jaws, especially in the morning?
- Smoke/Chew/Vape Tobacco?

Have you ever had:
- Orthodontic Treatment?
- Oral Surgery?
- Periodontal Treatment?
- Your teeth ground or the bite adjusted?
- A bite plate or mouth guard?
- A serious injury to the mouth or head?

If so, please describe, including cause:_____
_____

Have you experienced:
- Clicking or popping of the jaw?
- Pain? (joint, ear, side of face)
- Difficulty in opening or closing the mouth?
- Headaches, neck aches or shoulder aches?
- Sore muscles (neck, shoulders)?

Are you satisfied with your teeth's appearance?
- Would you like to keep all of your teeth all of your life?
- Do you feel nervous about having dental treatment?
  - If so, what is your biggest concern?
    _____
- Have you ever had an upsetting dental experience?
  - If so, please describe_____
    _____

Is there anything else about having dental treatment that you would like us to know?
If yes, please describe_____
_____
_____

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Directions to the office:
12502A Lake Ridge Drive

Coming from Fairfax Station, Occoquan or points north of the office heading south:

- Turn onto Old Bridge Road from 123
- The 5th traffic light will be Clipper Drive
- Turn right onto Clipper Drive
- Take the 2nd left turn onto Mayflower Drive
- First left into the parking lot and we are the second building on the right.

Coming from Dale City, Prince William Parkway or points south of the office heading north:

- Take Old Bridge Road heading north.
- Turn left onto Harbor Drive
- Turn right onto Mayflower
- Take the second right into the office complex off of Mayflower Drive.
  - We are the second building on the right.