ADVANCED SLEEP SOLUTIONS
OF VIRGINIA
SLEEP WELL

WELCOME TO OUR OFFICE!

We are pleased you have selected us to provide healthcare for you and your family. Our first responsibility is to provide the utmost in care at the lowest possible cost to you. One way we are able to keep our fees as low as possible is to reduce our billing and bookkeeping costs. So then, payment is expected at the time of treatment. And in order to provide the best care and avoid medication interactions, by signing the backside of this form, you authorize Dr. Queen to request a report utilizing Virginia's Prescription Monitoring Program of your past and current medications. Also, understand that there will be a minimal charge for broken appointments ($50/hour).

Date ___________________ Whom may we thank for referring you?____

What do you prefer to be called?____

PATIENT INFORMATION

Name____
Last First Middle

Address____
Street City Apt # State Zip

Sex: M F Date of Birth_____/______/____ Marital Status: Single/Married/Divorced/Widowed/Separated

Social Security #_________________________________Phone # (home/cell)___________________________________

Spouse's Name_________________________ How many children do you have? ______________________________

Patient Employed? Yes No Email address: ____

Employment Info____
Name Address City, State, Zip

RESPONSIBLE PARTY INFORMATION (if different than patient)

Name____
Last First Middle Initial

Address____
Street City State Zip Phone #

Sex M F Date of Birth_____/______/_____ Marital Status ____________ SS#______________________________

Employer____
Name Address City, State, Zip Phone #

Occupation____ Years at position________________________________

DENTAL & MEDICAL INSURANCE INFORMATION

Note: Filing of insurance claims to primary insurance carriers is done as a courtesy to our patients. If you have secondary insurance, we will be happy to provide you an itemized list of services so that you may submit to your secondary insurance provider for direct reimbursement.

Insurance Co.______________________________(MEDICAL)____(DENTAL)
Phone #___________________________________(MEDICAL)____(DENTAL)
Address___________________________________(MEDICAL)____(DENTAL)
Group Name_______________________________(MEDICAL)____(DENTAL)
Group #___________________________________(MEDICAL)____(DENTAL)
Effective Date____Relation to Patient____________________________

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MEDICAL HISTORY

Pharmacy name and number: ____

Physician's name and number: ____

Do you have any known health problems? **YES** **NO**

Are you currently under a physician's care? **YES** **NO**

What for?_______________________ Physician's Name and number___________________________________

Have you been hospitalized in the last two years? **YES** **NO**

What for?____

Are you now taking any medication or drugs? **YES** **NO**

If yes, please list:____

Are you allergic to any medication or anesthetics? **YES** **NO**

If yes, please list:____

Are you Pregnant? **YES** **NO** What month?________

Do you smoke or chew tobacco ? **YES** **NO** What?______________How Long?_______

Do you have or have you had any of the following conditions?

___Heart Disease/Attacks
___Rheumatic Fever
___Mitral Valve Prolapse
___Artificial Joints
___Congenital Heart Disease
___High/Low Blood Pressure
___Thyroid Problems
___Glaucoma
___Blood Diseases
___Diabetes I or II
___Drug Addiction
___Asthma
___Allergy to Metals
___Allergy to Latex
___Cortisone Medicine
___Emphysema
___Ulcers
___Arthritis
___Tuberculosis
___Kidney Disorder
___Venereal Disease
___Liver Disease
___Stroke
___Seizures
___Heart Murmur
___Cancer
___Pacemaker
___Sinus Trouble
___HIV or AIDS
___Sleep Apnea
___Snoring

Please list anything disease, condition or problem not listed above______________________________________

Consent:

1. The undersigned hereby authorizes the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with the patient. I understand that using anesthetic agents embodies certain risk. Furthermore, I authorize and consent that doctor chooses and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for services provided in this office for my dependents or myself is mine, due and payable at the time of service, unless other financial arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % finance charge (18% APR) may be added to my account in addition to any collection charges, and agree to pay reasonable attorney's fees. I further understand that any amount my insurance does not pay is my responsibility, as this office is not in control of third party payments. Additionally, I acknowledge that insurance coverage is not guaranteed and co-pay amounts are estimated, based on the benefits researched and outlined in my policy.
4. I understand that it is my responsibility to advise your office of any changes in the information on this form, personal and medical.
5. I authorize the use of my social security number to file my healthcare claim(s).

I understand the above information is necessary to provide me with healthcare in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I will not hold my doctor, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party_______________________________________**Date**_________________