Kim Ierna Kitchen, DDS PC and Associates

500 Montgomery Street #250
Alexandria, VA 22314
(703) 836-7000

Patient Information

Patient Name: _____ Date: _____
Last First MI

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

Social Security #: _____ Birth Date: _____

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

Email address: _____ May we contact you by email? ☐ Yes ☐ No

Address: _____
Street Apartment #

_____
City State Zip Code

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: _____

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information
We will assist in your insurance processing

Primary

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

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

Social Security #: _____

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: _____

Consent for Services

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination. Payments for dental treatment are due the time services are rendered. In addition to cash and checks, we accept Visa, MasterCard, American Express and Care Credit.

If you have dental insurance, it is our policy to help you receive the maximum benefits as we **DO NOT accept insurance as a payment**. However, as a courtesy to you, we will complete a claim form so that you can be reimbursed by your insurance company. You should understand that we have no relationship with your insurance company.

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 treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party