Dr. Inga Sloat, DMD/DS, PLLC
303 Maple Ave. Suite A Vienna VA. 22180
(703) 272-8596, (703) 272-8597 Fax 703-272-8598
Email: sloatdental@gmail.com

Today's Date _____

Patient Information

First Name _____ Last Name _____DOB_____SSN _____

Home Phone _____Cell Phone_____ Email _____

Address_____ City_____ State_____ Zip_____

Circle all that apply: Minor Single Married Divorced Separated Widowed

If Student, Name of School_____ City_____ State_____ FT/PT_____

Patient's or Parent's Employer_____ Work Phone_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

Person to Contact in Case of Emergency_____ Phone_____

Whom may we thank for referring you? _____

Responsible Person

Name of Person Responsible for this Account_____ Relationship_____

Address_____ Phone_____

Driver's License #_____ State_____ Date of Birth_____

Employer_____ Work Phone_____ SSN_____

Is this Person Currently a Patient of Dr. Sloat? Yes No

Insurance Information **(If same as person above, just write same)**

Name of Insured_____ Relationship_____

Date of Birth_____ SSN_____ Date Employed_____

Name of Employer_____ Work Phone_____

Address of Employer_____

Insurance Company_____ Group#_____ Policy/ID#_____

Insurance Company Address (if known)_____

What is your Deductible?_____ How much has been used?_____ Max. Amount_____

Authorization and Release

I certify that I have read the above information and that I have answered the questions accurately to the best of my knowledge. I authorize Dr. Sloat to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party health practitioners and/or payers. I authorize and request my insurance company to pay directly to the Dentist insurance benefits 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 rendered on my behalf or my dependents.

X_____ Signature of patient (or parent of minor)