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**Patient Information**

Name: \_\_\_\_\_ SSN#: \_\_\_\_\_  
 Phone: (Home) \_\_\_\_\_ (Cell): \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
 (Please Circle) Sex: Female Male Status: Single Married Widowed Divorced  
 Who may we thank for referring you? \_\_\_\_\_  
 General Dentists (If different from above): \_\_\_\_\_  
 Notify in case of emergency: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Primary Insurance:**

Policy holder (if other than patient): \_\_\_\_\_ SSN #: \_\_\_\_\_  
 Date of Birth: \_\_\_/\_\_\_/\_\_\_ Relationship: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Insurance Company Name: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_  
 Subscriber #/ID: \_\_\_\_\_ Group #: \_\_\_\_\_

**Additional Insurance**

Policy holder (if other than patient): \_\_\_\_\_ SSN #: \_\_\_\_\_  
 Date of Birth: \_\_\_/\_\_\_/\_\_\_ Relationship: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Insurance Company Name: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_  
 Subscriber #/ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

\*We participate with Virginia's Prescription Monitoring Program.