Virginia Family Dentistry

A TEAM APPROACH TO DENTAL CARE

PATIENT INFORMATION

Full Name_____ Nickname_____ Birthdate _____

(Please Check Your Answer) Sex: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Mailing Address_____ City_____ State_____ Zip_____

Physical Address_____ City_____ State_____ Zip_____

Work Phone_____ Home Phone_____ Cell Phone_____

Employer_____

Employer Address_____ City_____ State_____ Zip_____

Social Security Number_____ Email address_____

Names of family members who are patients here_____

Whom may we thank for referring you to our office_____

In case of emergency, who should be notified?

1) Name_____ Phone_____ 2) Name_____ Phone_____

PERSON RESPONSIBLE FOR THIS ACCOUNT

(If patient is a minor child, please complete the next 2 sections for the child's parents)

Name_____ Relationship to Patient_____ Birth Date_____

Home Address (if different from above)_____

Employer_____ **Social Security Number**_____

Business Address_____

Home Phone_____ Work Phone_____ Cell Phone_____

PATIENT'S SPOUSE OR OTHER PARENT

Name_____ Relationship to Patient_____ Birth Date_____

Home Address (if different from above)_____

Employer_____ **Social Security Number**_____

Business Address_____

Home Phone_____ Work Phone_____ Cell Phone_____

INSURANCE INFORMATION

Dental Insurance_____Yes_____No Effective Date_____

Subscriber's Name_____

Subscriber's Birth Date_____

Subscriber's Employer_____

Insurance Company_____

Group No._____SSN/Contract No._____

Medical Insurance _____Yes _____No Effective Date_____

Subscriber's Name_____

Subscriber's Birth Date_____

Subscriber's Employer_____

Insurance Company_____

Group No._____SSN/Contract No._____

SECONDARY INSURANCE INFORMATION

Dental Insurance_____Yes_____No Effective Date_____

Subscriber's Name_____

Subscriber's Birth Date_____

Subscriber's Employer_____

Insurance Company_____

Group No._____ SSN/Contract No._____

Medical Insurance _____Yes _____No Effective Date_____

Subscriber's Name_____

Subscriber's Birth Date_____

Subscriber's Employer_____

Insurance Company_____

Group No._____SSN/Contract No._____

PLEASE CONTINUE WITH BACK OF FORM...

MEDICAL HISTORY

Name of Your Primary Care Physician_____ _____Phone_____

Date of last physical_____

Are you taking any MEDICATION now (PRESCRIPTION AND/OR OVER-THE-COUNTER)? _____ YES _____ NO

If yes, please list_____

Are you pregnant? YES ☐ NO ☐ Do you take hormones? YES ☐ NO ☐ Do you take birth control pills? YES ☐ NO ☐

Do you have a history of any of the following (please circle all that apply)?

ALCOHOLISM
ANEMIA
ANY BLEEDING PROBLEMS
ANY CHRONIC INFLAMMATORY DISEASE I.E. LUPUS
ANY JOINT REPLACEMENT
ARTHRITIS
ASTHMA
BONE DISORDERS
CANCER
DIABETES
DRUG ABUSE/TREATMENT
EMOTIONAL PROBLEMS
EMPHYSEMA
FREQUENT HEADACHES
GROWTH DISORDERS
HEARING LOSS
HEART ATTACK
HEART MURMUR
HEPATITIS
HERPES (FEVER BLISTERS)
HIGH BLOOD PRESSURE
KIDNEY DISORDERS
LEUKEMIA
LIVER DISEASE
LOW BLOOD PRESSURE
MITRAL VALVE PROLAPSE
NERVOUS/ANXIOUS
OPEN HEART SURGERY
PACE MAKER
RECREATIONAL DRUG USE
RHEUMATIC HEART DISEASE
RHEUMATIC FEVER
SEIZURES
SICKLE CELL ANEMIA
SINUS CONDITION
SKIN DISEASE
STOMACH OR INTESTINAL ILLNESS
STROKE
TESTED HIV POSITIVE
THYROID DISEASE
TUBERCULOSIS
ULCERS
VENEREAL DISEASE

Do you have a history of allergies to:

MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) YES ☐ NO ☐ If yes, please list_____

LOCAL ANESTHESIA YES ☐ NO ☐ _____

OTHER (foods, respiratory, fluoride, etc.) YES ☐ NO ☐ _____

ADDITIONAL INFORMATION ABOUT YOUR HEALTH THAT WE SHOULD KNOW:_____

_____

Have you ever had any unusual reactions to any drug or anesthetic? YES ☐ NO ☐ _____

Is there any other information about your health that we should know? YES ☐ NO ☐ _____

DENTAL HISTORY

Name of your former dentist:_____ Date of last appointment_____

Address_____ Phone_____

Do you want full dental care? _____ Yes _____ No An estimate of treatment charges will be given.

Reason for first visit with us _____

Please add anything that you feel is important for the doctor to know: _____

_____

PAYMENT OF PROFESSIONAL FEES

Payment at the time of services is expected. For your convenience, we accept VISA and MASTERCARD. Our office will be happy to submit claims to your insurance company. A service charge of 1 1/2 % per month will be added to all balances 60 days and older. The annual rate of the service charge is 18%.

I understand that Virginia Family Dentistry will make every effort to collect from my insurance company. I hereby authorize Virginia Family Dentistry to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services rendered to me or my dependents. By signing this form, I acknowledge and understand that I am responsible for any amounts not covered by insurance for services rendered to me or my dependents. I also acknowledge and understand that if the account is turned over to an attorney or collection agency for collection, I here agree to pay thirty percent (30%) attorney or collection agency fees on the unpaid balance.

Date _____ Signature _____