Virginia Family Dentistry

A TEAM APPROACH TO DENTAL CARE

PATIENT INFORMATION

Patient's Name_____ Nickname_____ Birthdate _____ Male ☐ Female ☐

Address_____City_____State_____Zip_____

Home Phone_____ Work Phone_____ Cell_____ SS#_____

Email address_____

If patient is a minor, give custodial parents or legal guardian's name_____

Names of family members who are orthodontic patients here_____

Whom may we thank for referring you to our office_____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Marital Status: ☐☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single Spouse Name _____

Name_____Email_____

Address_____

Mailing Address_____

Home Phone_____ Work_____ Cell_____

SS#_____ Birthdate_____Relationship to Patient_____

PATIENT'S SPOUSE OR OTHER PARENT

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single Spouse Name _____

Name_____Email_____

Address_____

Mailing Address_____

Home Phone_____ Work_____ Cell_____

SS#_____ Birthdate_____Relationship to Patient_____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company_____ Subscriber's Name_____Subscriber's Birthdate_____

Employer_____Address_____Phone_____

Group #_____ Subscriber ID or SS#_____Insurance Phone #_____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company_____ Subscriber's Name_____Subscriber's Birthdate_____

Employer_____Address_____Phone_____

Group #_____ Subscriber ID or SS#_____Insurance Phone #_____

Emergency Contact

Emergency Contact_____ Phone_____

Relationship to patient_____

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 ½% 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, P.C. will make every effort to collect from my insurance company. I hereby authorize Virginia Family Dentistry, P.C. 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 for collection, I hereby agree to pay thirty percent (30%) attorney or collection agency fees on the unpaid balance.

Date_____ Signature_____

MEDICAL HISTORY

Patient_____

Physician_____City_____Phone_____

Does the patient:

Yes	No	
☐	☐	Have any health problems? Explain_____
☐	☐	Take any medications? List_____
☐	☐	Have allergic reactions to medications? List_____
☐	☐	Currently see a physician? Explain_____
☐	☐	Had their tonsils and adenoids removed? When_____
☐	☐	Take medications for osteoporosis or other bone disorders (e.g. biophosphates?) List _____
☐	☐	Have an allergic reaction to latex?
☐	☐	Have an allergic reaction to metal (jewelry or clothing snaps)?

Please check if **patient** has (currently or in the past) had any of the following conditions:

	Yes	No		Yes	No		Yes	No
Heart Murmur	☐	☐	Hives/Rash	☐	☐	Autism/Asperger's	☐	☐
Heart Surgery	☐	☐	Diabetes	☐	☐	Frequent Headaches	☐	☐
Rheumatic Fever	☐	☐	Kidney Disease	☐	☐	ADD/ADHD	☐	☐
High Blood Pressure	☐	☐	Liver Disease/Hepatitis	☐	☐	Cancer	☐	☐
Prolonged Bleeding	☐	☐	Tuberculosis	☐	☐	Bone Disorders	☐	☐
Anemia	☐	☐	Bronchitis	☐	☐	Growth Disorders	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Herpes (Fever Blisters)	☐	☐
Endocrine Disorders	☐	☐	Epilepsy/Seizures	☐	☐	Arthritis/Rheumatism	☐	☐
Developmental Disorder	☐	☐	Fainting	☐	☐	Currently Pregnant	☐	☐
HIV/AIDS	☐	☐				If pregnant,due? _____		

Any other conditions or problems that we should know about (e.g. Nervous, anxious, emotional problems)? _____

Growth information for patients under 16 – Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid our treatment alternatives: Has Patient:

Reached puberty	☐ Yes	☐ No	
Girls – started menstruation?	☐ Yes	☐ No	When?_____
Boys – voice changed?	☐ Yes	☐ No	When?_____
Do you feel growth is completed?	☐ Yes	☐ No	Father's Height_____Mother's Height_____
Have siblings or parents been treated with orthodontics?	☐ Yes	☐ No	

DENTAL HISTORY

Current Dentist_____City_____

Are you or your child sensitive or self-conscious about your teeth or smile? ☐ Yes ☐ No

What is your chief concern with your (or your child's) teeth?_____

Frequency of dental checkups: Twice a yr ☐ Once a yr ☐ Only if problem exists ☐ Never ☐ Date of last visit_____

Is there any unfinished care to be complete with your dentist?	☐ Yes	☐ No	Explain:_____
Are you frightened about dental treatment?	☐ Yes	☐ No	Explain:_____
Have you had any face or dental injuries?	☐ Yes	☐ No	Explain:_____
Do you play any musical instrument?	☐ Yes	☐ No	What instrument?_____
Have you consulted with an orthodontist previously?	☐ Yes	☐ No	With whom?_____
Have teeth (either primary or permanent) been removed?	☐ Yes	☐ No	Explain:_____
Have you had any previous orthodontic treatment?	☐ Yes	☐ No	With whom?_____
Are you satisfied with prior treatment?	☐ Yes	☐ No	Explain:_____
Is there a history of thumb or finger sucking?	☐ Yes	☐ No	How long:_____
Do you have supernumerary (extra) or congenitally missing teeth?	☐ Yes	☐ No	Explain:_____

Please check if there is a history of:

☐ Clenching teeth	☐ Muscular soreness around head and neck	☐ Jaw joint soreness	☐ Jaw joint popping
☐ Grinding teeth	☐ Headaches (more than normal)	☐ Jaw joint clicking	☐ Ringing in ears
☐ Speech problems (If so, what sounds?_____)		☐ Mouth breathing (circle): awake asleep	
☐ Difficulty in chewing	☐ Periodontal or gum treatment (If so, Explain_____)		

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

Patient's Signature_____Parent/Guardian Signature (if minor)_____Date_____