

Welcome to Virginia Dental Solutions

Patient Information

Last Name: _____ First Name: _____ MI: _____
 Male Female Title: Please Circle MR. MS. DR. Other _____

Home Address: _____
(Street Address) (Apt/Suite#) (City) (State) (Zip Code)

Employer's Name: _____ Date of Birth: ____/____/____

Business Address: _____ Social Security#: _____-_____-_____

Name & Number & Relationship of Nearest Living Relative Home Telephone: (____) _____-_____

_____ Business Telephone: (____) _____-_____

Whom May We Thank For Referring You To The Office? Cell/Pager/Other: (____) _____-_____

_____ E-Mail address _____@_____

Spouse Information (if applicable)

Last Name: _____ First Name: _____ MI: _____

Social Security#: _____-_____-_____ Date of Birth: ____/____/____

Home Phone: (____) _____-_____ Business Phone: (____) _____-_____

Employer's Name & Address: _____

Responsible Party Information

Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: Self Parent Guardian Spouse Other: _____ Date Of Birth: ____/____/____

Address (If Different From Patient): _____
(Street Address) (Apt/Suite#) (City) (State) (Zip Code)

Home Phone #: (____) _____-_____

Social Security #: _____-_____-_____ Cell/Pager/Other #: (____) _____-_____

Employer's Name: _____ Business Phone #: (____) _____-_____

FINANCIAL AGREEMENT: I understand and agree that the payment of my bill is my obligation, regardless of how much my insurance covers. All filings of insurance papers, confirmation of insurance coverage, and/or payments are my responsibility. We will do our utmost to help you understand your insurance benefits and file your claims for you, however any assistance in these matters provided by the doctor and/or staff is strictly a courtesy and implies no responsibility on their part for filing, follow-through, or confirmation of coverage. The undersigned is aware that a charge of \$100/hour of scheduled time may be made for broken appointments or those cancelled under 24 hours. In the event that this account should become delinquent and is placed in the hands of an attorney for collection, I agree to pay the balance due, and interest at the rate of 1.5% per month (18% per annum), beginning 30 days after the monies were due or expenses were incurred, all court costs, and attorney fees of 33-1/3% of the principal and interest owing. I further agree to pay returned check charges of \$35.00 per returned check. I understand and agree that this agreement is reaffirmed each time either I and/or any member of my family receives services.

X _____
Responsible Party Signature

____/____/____
Date

HIPAA (Health Insurance Portability and Accountability Act) **Acknowledgement of Receipt of Notice of Privacy Practices.** By Signing Below, The Patient/Responsible Party Certifies That They Have Received A Copy Of The Notice Of Privacy Practices For This Office.

X _____
Responsible Party Signature

____/____/____
Date

MEDICAL HISTORY

Medical Doctor's Name & Phone Number: _____ (____) _____-

Are You Under a Doctor's Care Now? No Yes If Yes, Why? _____

Have You Ever Been Hospitalized? No Yes If Yes, When? _____

Are You Allergic To: Penicillin Codeine Aspirin Local Injected Anesthetic Latex Other: _____

Are You Taking Any Medications? No Yes If Yes, What? _____

Are You Pregnant? No Yes If Yes, What Week? _____

Have You Ever Been Told By Your Physician To Pre-Medicate Before Dental Visits? No Yes If Yes, With What Medication? _____

Do You Smoke? No Yes If Yes, How Much? _____ How Many Years? _____ Do you use any tobacco products? _____ (specify)

Please Check All That Apply:

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> AIDS (HIV) | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Swelling Of Ankles/Feet | <input type="checkbox"/> STD's | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> X-Ray/Cobalt Tx |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Chemotherapy/Radiation |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis/Gout |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Blood Disease/Disorder | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Anemia | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis(Which kind?__) | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Allergies | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Addiction_____ |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Autism |

Do You Have Any Other Medical Conditions That May Not Be Listed Above? No Yes If Yes, What? _____

Reason for This Visit: _____

Name and Address of Previous Dentist: _____

Date of Last Dental Visit: _____ Date Of Last Full Mouth/Panoramic X-Ray: _____ Date of Last Bitewing X-Rays: _____

- | | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Have You Ever Had A Problem With Dental Treatment? | <input type="checkbox"/> | <input type="checkbox"/> | Do You Wear Partial Or Dentures? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do Your Gums Bleed Easily? | <input type="checkbox"/> | <input type="checkbox"/> | Have You Ever Had Gum Surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do You Gag Easily? | <input type="checkbox"/> | <input type="checkbox"/> | Are You Happy With The Appearance of Your Smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Do You Clench Or Grind Your Teeth? | <input type="checkbox"/> | <input type="checkbox"/> |

Please Add Anything Else You Feel Is Important For Us To Know: _____

Printed Name (Patient) _____ Signature (Patient or Guardian) _____ Date _____

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