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:

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

	Yes	No
Have You Ever Had A Problem With Dental Treatment?	☐	☐
Do Your Gums Bleed Easily?	☐	☐
Do You Gag Easily?	☐	☐

	Yes	No
Do You Wear Partials Or Dentures?	☐	☐
Have You Ever Had Gum Surgery?	☐	☐
Are You Happy With The Appearance of Your Smile?	☐	☐
Do You Clench Or Grind Your Teeth?	☐	☐

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

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

Gary L. Hartz, D.M.D. ■ Robert G. Hall, D.D.S.
Kendra E. Novick, D.D.S. ■ Sumit Sharma, D.D.S. ■ Luis J. Martinez,
D.D.S. Brian Lee, D.D.S. ■ Bruce Svechota-Kingsbury, D. D.S.

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