Harrisonburg Family Dentistry

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU-THANK YOU

PATIENT LAST NAME_____FIRST_____MIDDLE INITIAL_____

HOW DID YOU HEAR ABOUT US?_____ WHOM CAN WE THANK FOR REFERAL_____

Date of Birth_____Single_____Married_____Divorced_____Male_____Female_____

Telephone (Home) _____(Mobile)_____(Work)_____

Physical Address_____ PO Box (if applies)_____

City _____State_____Zip_____

Email_____Employer_____

Occupation_____ Social Security #_____

Husband, Wife, or Other Responsible Party (If Not Self)

Last Name_____ First_____ Middle Initial_____ DOB_____

Physical Address_____ PO Box (If applies)_____

City _____State_____Zip_____

Telephone (Home) _____(Mobile)_____(Work)_____Email_____

Employer_____Occupation_____Social Security#_____

Dental Insurance Information:

Name _____Group#_____ID#_____

Subscriber Name _____DOB_____Address_____

Is patient covered by another dental insurance? ____yes ____no Insurance Co._____

Emergency Contact:

Name_____Relationship_____Phone_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

DENTAL HISTORY AND CONSENT FOR TREATMENT

Reason for seeking dental care at this time _____

Date of last dental visit _____ Reason? _____ Date of last X-rays _____

Former dentist _____ City/state _____

How often do you: **Brush** _____ times per _____ **Floss** _____ times per _____

How do you feel about dental treatment? Relaxed A little uneasy Tense Anxious Very Anxious

Do you have or have you ever had any of the following? Please mark boxes and comment.

☐Aching or sensitive teeth	☐Broken filling	☐Areas of food traps	☐Unfavorable dental experience
☐Sensitive or bleeding gums	☐Loose teeth	☐Difficulty opening wide	☐Growths or lesions in your mouth
☐Broken or missing teeth	☐Bad breath	☐Clicking or popping in jaw	☐Cold sores
☐Grinding or clenching	☐Swollen glands	☐Jaw pain or tiredness	☐Dry mouth
☐Swelling or lumps in mouth	☐Gum infection	☐Orthodontic treatment	☐Other _____

If you could change your smile, what would you change?

☐Remove unsightly fillings	☐Straighten teeth	☐Change shape of teeth	☐Close gaps between teeth
☐Replace missing teeth	☐Whitening	☐Make teeth same color	☐Other _____

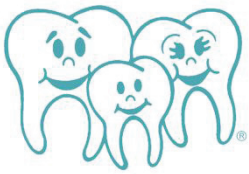
Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Signature of patient or authorized responsible party	Relationship	Date

DENTAL HISTORY AND CONSENT FOR TREATMENT



Harrisonburg Family Dentistry
1741 Virginia Avenue Suite G
Harrisonburg, Virginia 22802
540-209-8090

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I,_____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
Print Name Relationship

_____ _____
Print Name Relationship

_____ _____
Print Name Relationship

Harrisonburg Family Dentistry
1741 Virginia Avenure Suite G
Harrisonburg, VA 22802

Office, Insurance, and Financial Policies

Thank you for choosing our office for your dental needs. We require patients to read and sign the office, insurance, and financial policies before treatment. Please let us know if you have any questions or concerns regarding the following policies.

Insurance: We may accept assignment of insurance benefits after you provide us with your full insurance information and we are able to reach your insurance carrier to verify that information. **We require that you pay your deductible and your estimated patient portion at the time of service.** If your insurance company has not made a payment within 45 days of billing, the balance will become your responsibility. We will file pre-treatment estimates at your request only. Some insurance companies may not honor a pre-treatment estimate or may alter it. Not all services are covered by insurance, in the event your insurance plan determines a service to be "not covered", down-coded" or if "alternative benefits" are given you will be responsible for the differences or for the non-covered charges. It is your responsibility to know your insurance benefits; the practice is not liable when and if there is an insurance discrepancy. Our office does not guarantee your eligibility and coverage.

Dental Insurance: I authorize and release information and payment of my dental insurance to my dentist. The above named dentists may use my health care information and may disclose such information to my insurance carriers.

Minor patients: The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized for payment by: Visa, Mastercard, Discover, American Express, Cash, no checks will be accepted for payment.

Missed appointments: We reserve the right to charge **$50** for appointments broken without the proper **24** hour notice. Please help us serve you better by keeping your scheduled appointments; broken or missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

Significant exposure: Section 32.1-45, 1 (A) and (B), Code of VA. (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus, and Hepatitis Virus is considered to have been given by the patient and/or healthcare worker thereby granting the hospital the right to perform such tests. Test results are confidential and can only be released in accordance with the applicable laws and the policy of the treating hospital.

I have read and understand fully the financial options. I agree to accept responsibility for payment of my account balance and my family member's account balance _____ _____(names of the family members) including co-payments and non-covered services requested by me or my family members. In lieu of a refund I authorize any credits on my account to be transferred to my family member's account and I understand I will be billed for any outstanding balance after the credit is applied to the family account balance unless otherwise directed. I understand that in the event my account becomes delinquent, I will be responsible for any collections, attorney fees at 25%, court costs, and any other charges incurred to this account (pre-collection fees, etc.). I authorize and release information and payment of my dental insurance to the dentist.

Printed Name_____**Date**_____

Signature of patient or responsible party_____