NEW PATIENT FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Patient Information

Family Dental Group
116 N Railroad Ave
Ashland, VA 23005

Date: _____

Name: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Address: _____
Street Address

_____
City State Zip

How long have you been living at this address? _____

Employer: _____

Occupation: _____

Social Security Number: _____

Date of Birth: _____ Sex: □ Male □Female

Height: _____ Weight: _____

Marital Status:
□ Never Married □ Married □ Domestic Partnership □ Divorced □ Widowed

Emergency Contact Information:

Name: _____

Relation: _____

Emergency Phone: _____

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DENTAL HEALTH HISTORY
(Confidential)

Today's Date_____

Patient Name_____ Birthdate_____
Last First Initial

DENTAL HISTORY

Reason for Today's Visit_____

Former Dentist_____

Address_____

Date of last dental care_____ Date of last dental X-rays_____

Check (✓) if you have had problems with any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit_____

Have you had any serious illnesses or operations?_____ If yes, describe_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe_____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name_____

Phone_____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_____

_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

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AGREEMENT TO PAY FOR TREATMENT

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

I, THE RESPONSIBLE PARTY LISTED BELOW, HEREBY AGREE TO PAY ALL CHARGES SUBMITTED BY THIS OFFICE DURING THE COURSE OF TREATMENT FOR THE PATIENT.

If the patient is insured with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable deductibles and co-payments which may arise during the course of treatment for the patient. All co-pays are expected to be paid at the time of service. The responsible party is also required to pay for treatment rendered to the patient which is not considered to be a covered service by third party insurers.

Missed Appointment Policy - If a patient schedules an appointment and fails to show up or cancel the appointment at least one hour in advance they will be considered a "no show" for that visit. Insured patients who have two "no show" visits at the clinic will be charged a $25.00 no show fee for every missed appointment thereafter. This fee is not covered by insurance and is the patients' responsibility. We have created this policy in an effort to be able to see patients in need as quickly as possible.

Bad Check Policy - All bounced checks will be retrieved through electronic payment systems. There will be a fee to the patient for this recovery service.

Collection Policy – If we are forced to send a patient to collections for failure to make payment or if patient declares bankruptcy they will be expected to pay all charges in advance for any future appointments. If a patient is sent to collections a second time they, and their financial dependents, will be dismissed from the clinic.

_____ _____

Printed Name Signed Name

_____

Date

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RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER.

I, the responsible party listed above, hereby authorize this office, including its employees, to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my child's medical records to any other entity, including, but not limited to specialty hospitals, physicians or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of any records necessary to assist in the reimbursement of insurance benefits to which I may be entitled.

I, authorize the office and its employees to release medical records which are needed in ordered to provide the patient with the most appropriate medical care.

I, authorize and request the payment of my third party or insurance company benefits be made directly to this office for any services or treatments given to the patient. The signature provided below shall suffice for all insurance forms on a continuing basis.

_____ _____

Printed Name Signed Name

_____

Date