



# Virginia Family Dentistry

A TEAM APPROACH TO DENTAL CARE

## PATIENT INFORMATION

### PERSONAL INFORMATION

Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Gender:  Male  Female  Transgender  Non-binary  Prefer not to say Preferred Pronouns:  He/Him  She/Her  They/Them

Marital Status:  Single  Married  Separated  Divorced  Widowed

Mailing Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email address: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Names of family members who are patients here: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

In case of emergency, who should be notified?

1) Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

2) Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### PERSON RESPONSIBLE FOR THIS ACCOUNT

(If patient is a minor child, please complete the next 2 sections for the child's parents)

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_

Home Address (if different from above) \_\_\_\_\_

Employer \_\_\_\_\_ Social Security Number \_\_\_\_\_

Business Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### PATIENT'S SPOUSE OR OTHER PARENT

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_

Home Address (if different from above) \_\_\_\_\_

Employer \_\_\_\_\_ Social Security Number \_\_\_\_\_

Business Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

PLEASE CONTINUE WITH BACK OF FORM...



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## INSURANCE INFORMATION

### PRIMARY INSURANCE INFORMATION

Dental Insurance:  Yes  No Effective Date: \_\_\_\_\_ Medical Insurance:  Yes  No Effective Date: \_\_\_\_\_  
 Subscriber's Name: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_  
 Subscriber's Birth Date: \_\_\_\_\_ Subscriber's Birth Date: \_\_\_\_\_  
 Subscriber's Employer: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
 Group No.: \_\_\_\_\_ SSN/Contract No.: \_\_\_\_\_ Group No.: \_\_\_\_\_ SSN/Contract No.: \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Dental Insurance:  Yes  No Effective Date: \_\_\_\_\_ Medical Insurance:  Yes  No Effective Date: \_\_\_\_\_  
 Subscriber's Name: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_  
 Subscriber's Birth Date: \_\_\_\_\_ Subscriber's Birth Date: \_\_\_\_\_  
 Subscriber's Employer: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
 Group No.: \_\_\_\_\_ SSN/Contract No.: \_\_\_\_\_ Group No.: \_\_\_\_\_ SSN/Contract No.: \_\_\_\_\_

## CANCELLATION POLICY

We are very pleased to participate in your dental healthcare, and have set aside time for your appointment. We understand that sometimes it is necessary to cancel or change an appointment. In consideration of the others who need care, we ask that if you are unable to keep an appointment with our office, that you please observe our cancellation policy which follows:

**Our office requires at least 24 hours' notice for all appointment cancellations. If you are unable to provide 24 hours' notice, you will be billed a \$45.00 charge for your scheduled appointment time.**

Date \_\_\_\_\_ Signature \_\_\_\_\_

## 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 90 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 or collection agency 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                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any health problems? Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Take any medications? List _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have allergic reactions to medications? List _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Currently see a physician? Explain _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Had their tonsils and adenoids removed? When _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Take medications for osteoporosis or other bone disorders (e.g. biophosphates?) List _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have an allergic reaction to latex?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 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	<input type="checkbox"/>	<input type="checkbox"/>	Hives/Rash	<input type="checkbox"/>	<input type="checkbox"/>	Autism/Asperger's	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Growth Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Herpes (Fever Blisters)	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>				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  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |   |
| Girls – started menstruation?                            | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | When? _____                                 |
| Boys – voice changed?                                    | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | When? _____                                 |
| Do you feel growth is completed?                         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Father's Height _____ Mother's Height _____ |
| Have siblings or parents been treated with orthodontics? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | 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:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Clenching teeth                             | <input type="checkbox"/> Muscular soreness around head and neck              | <input type="checkbox"/> Jaw joint soreness | <input type="checkbox"/> Jaw joint popping |
| <input type="checkbox"/> Grinding teeth                              | <input type="checkbox"/> Headaches (more than normal)                        | <input type="checkbox"/> Jaw joint clicking | <input type="checkbox"/> Ringing in ears   |
| <input type="checkbox"/> Speech problems (If so, what sounds? _____) | <input type="checkbox"/> Mouth breathing (circle): awake asleep              |   |  |
| <input type="checkbox"/> Difficulty in chewing                       | <input type="checkbox"/> 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 \_\_\_\_\_