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: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Email address: _____

Employer: _____ 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 ON SECOND PAGE ...

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PRIMARY INSURANCE INFORMATION

Dental Insurance: ☐ Yes ☐ No Effective Date: _____
Subscriber's Name: _____
Subscriber's Birth Date: _____
Subscriber's Employer: _____
Insurance Company: _____
Group #: _____ SSN/Contract #: _____

Medical Insurance ☐ Yes ☐ No Effective Date: _____
Subscriber's Name: _____
Subscriber's Birth Date: _____
Subscriber's Employer: _____
Insurance Company: _____
Group #: _____ SSN/Contract #: _____

SECONDARY INSURANCE INFORMATION

Dental Insurance: ☐ Yes ☐ No Effective Date: _____
Subscriber's Name: _____
Subscriber's Birth Date: _____
Subscriber's Employer: _____
Insurance Company: _____
Group #: _____ SSN/Contract #: _____

Medical Insurance ☐ Yes ☐ No Effective Date: _____
Subscriber's Name: _____
Subscriber's Birth Date: _____
Subscriber's Employer: _____
Insurance Company: _____
Group #: _____ SSN/Contract #: _____

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 $100.00 charge for your scheduled appointment time.

Patient's Signature: _____ **Parent/Guardian Printed Name (If minor):** _____

Parent/Guardian Signature (If minor): _____ **Date:** _____

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 0.25% per month will be added to all balances 90 days and older. The annual rate of the service charge is 3%.

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 my account is turned over to a law firm for collection, I hereby agree to pay thirty-three and one-third percent (33.33%) attorney's fees on the unpaid balance. Furthermore, the law firm may take such legal actions as the filing of warrants in debt and wage garnishments in the collection of the balances owed. In the event an account is turned over to a collection agency, I hereby agree to pay fees of 30% on the unpaid balance.

Patient's Signature: _____ **Parent/Guardian Printed Name (If minor):** _____

Parent/Guardian Signature (If minor): _____ **Date:** _____

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MEDICAL HISTORY

PERSONAL INFORMATION

Patient Name: _____ **Birth Date:** _____

Primary Care Physician's name (If a child, Pediatrician's) _____ Phone: _____

Approximate date of most recent visit to Primary Care Physician: _____

MEDICATIONS

Do you regularly take any medication (prescription and/or over the counter)? ☐ Yes ☐ No

If yes, please list: _____

Do you take any medications that thin your blood (Aspirin, Eliquis, Xarelto, Coumadin, Plavix)? ☐ Yes ☐ No

Have you ever taken medication for osteoporosis, either tablet or injection (Actonel, Fosamax, Boniva, Reclast, Aredia)? ☐ Yes ☐ No

Are you currently taking immunosuppressant drugs or undergoing chemotherapy? ☐ Yes ☐ No

Have you ever been told by a doctor to take an antibiotic prior to dental appointments ☐ Yes ☐ No

ALLERGIES

Do you have an allergy or have you had a bad reaction to any of the following?

☐ Penicillin ☐ Codeine ☐ Ibuprofen ☐ Sulfa Drugs ☐ Latex ☐ Local Anesthetic ☐ Metal/Nickel ☐ Other: _____

CONDITIONS

Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Do you use tobacco? ☐ Frequent ☐ Occasional ☐ Never If so, what form? ☐ Cigarettes ☐ Vape ☐ Smokeless

Do you drink alcohol? ☐ Frequent ☐ Occasional ☐ Never Do you use marijuana? ☐ Frequent ☐ Occasional ☐ Never

Have you had or are you currently undergoing radiation treatment in your head and neck? ☐ Yes ☐ No

Please check all the following that apply:

☐ Heart Attack, date: _____	☐ Asthma	☐ Kidney Disease
☐ Stroke, date: _____	☐ COPD	☐ Hepatitis, type: _____
☐ Heart Disease	☐ Sleep Apnea	☐ Drug Use Disorder
☐ High Blood Pressure	☐ Diabetes	☐ AIDS/HIV positive
☐ Bleeding Disorder	☐ Cancer, type: _____	☐ Artificial Joint, date: _____
☐ Pace Maker	☐ Thyroid disorder	☐ Artificial Heart Valve

☐ Please list any additional conditions: _____

DENTAL HISTORY

Name of your previous dentist: _____

Most recent check-up/dental cleaning: ☐ Within 6 months ☐ 6 months to 1 year ☐ 1 – 2 years ☐ more than 2 years

Reason for first visit with us _____

Are you anxious about dental treatment? ☐ Yes ☐ No If yes, are you interested in Nitrous Oxide or Sedation? ☐ Yes ☐ No

Are you interested in any of the following cosmetic treatments? ☐ Whitening ☐ Orthodontics/Invisalign ☐ Veneers/Bonding

Do you use any oral appliances? ☐ Nightguard ☐ Retainer ☐ Sleep Apnea Device

ADDITIONAL INFORMATION YOU THINK WE SHOULD KNOW

Patient's Signature: _____ **Parent/Guardian Printed Name (If minor):** _____

Parent/Guardian Signature (If minor): _____ **Date:** _____