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: ____________________

Subscriber's Name: ____

Subscriber's Birth Date:_____________________________________

Subscriber's Employer: _____________________________________

Insurance Company:____

Group No.: ________________ SSN/Contract No.:________________

Medical Insurance: ☐Yes ☐No Effective Date: __________________

Subscriber's Name: ____

Subscriber's Birth Date:_____________________________________

Subscriber's Employer: _____________________________________

Insurance Company: ____

Group No.:________________ SSN/Contract No.:________________

SECONDARY INSURANCE INFORMATION

Dental Insurance: ☐Yes ☐No Effective Date: ____________________

Subscriber's Name: ____

Subscriber's Birth Date:_____________________________________

Subscriber's Employer: _____________________________________

Insurance Company:____

Group No.: _______________ SSN/Contract No.:________________

Medical Insurance: ☐Yes ☐No Effective Date: __________________

Subscriber's Name: ____

Subscriber's Birth Date:_____________________________________

Subscriber's Employer: _____________________________________

Insurance Company: ____

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 $100.00 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____

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MEDICAL HISTORY FOR ORTHODONTIC TREATMENT

PERSONAL INFORMATION

Patient Name: ____________________

Physician: ____________________ City: ____________________ Phone: ____________________

MEDICATIONS

Are you currently taking medications? (with or without prescriptions) ◻ *Yes* ◻ *No* If yes, give details: ____________________

Are you currently taking, or have a history of taking medicine for osteoporosis or other bone disorders? (e.g. bisphosphonates)? ◻ *Yes* ◻ *No*

If yes, give details: ____________________

ALLERGIES

Have you had an allergic reaction to the following?

☐ *Latex* ☐*Metal/Nickel(Including jewelry or clothing snaps)* ☐ *Medication:* ____________________ ☐ *Other:* ____________________

OTHER

Are you currently seeing a physician? ◻ *Yes* ◻ *No* If yes, please explain: ____________________

Do you have any health problems? ◻ *Yes* ◻ *No* If yes, please explain: ____________________

Have you had your tonsils and adenoids removed? ◻ *Yes* ◻ *No* If yes, when? ____________________

Do you use Tobacco/Vape? ◻ *Daily* ◻ *Weekly* ◻ *Monthly* ◻ *Never*

Do you use Marijuana? ◻ *Daily* ◻ *Weekly* ◻ *Monthly* ◻ *Never*

PLEASE CHECK IF THE PATIENT HAS ANY OF THE FOLLOWING CONDITIONS CURRENTLY OR IN THE PAST.

◻ *ADD/ADHD*	◻ *Blood Disease*	◻ *Endocrine Disorders*	◻ *Frequent Headaches*	◻ *Kidney Disease*
◻ *Anemia*	◻ *Bone Disorders*	◻ *HIV/AIDS*	◻ *Growth Disorders*	◻ *Prolonged Bleeding*
◻ *Asthma*	◻ *Bronchitis*	◻ *Hives/Rash*	◻ *Heart Murmur*	◻ *Rheumatic Fever*
◻ *Autism/Asperger's*	◻ *Cancer*	◻ *Liver Disease/Hepatitis*	◻ *Heart Surgery*	◻ *Tuberculosis*
◻ *Arthritis/Rheumatism*	◻ *Developmental Disorder*	◻ *Epilepsy/Seizures*	◻ *Herpes (Fever Blisters)*	◻ *Pregnant? If yes, due date?*
◻ *Artificial Joints*	◻ *Diabetes*	◻ *Fainting*	◻ *High Blood Pressure*	____________________

GROWTH INFORMATION FOR PATIENTS UNDER 16

Growth can be an important factor in orthodontic treatment planning. Your answers to the following questions are needed to aid our treatment alternatives.

Has the patient reached puberty? ☐ *Yes* ☐ *No*

Do you feel growth is completed? ☐ *Yes* ☐ *No* Father's Height:_______ Mother's Height:_______

Have siblings or parents been treated with orthodontics? ☐ *Yes* ☐ *No*

Girls – started menstruation? ☐ *Yes* ☐ *No* If yes, when?______________ **Boys** – voice changed? ☐ *Yes* ☐ *No* If yes, when?______________

ARE THERE ANY OTHER CONDITIONS/ PROBLEMS WE SHOULD KNOW ABOUT? (E.g., nerves, anxiety, emotional problems)

DENTAL HISTORY

Current Dentist: ____________________ City: ____________________

When was your last Dentist visit? __________ Frequency of Dental Checkups: ◻ *Twice a Year* ◻ *Once a year* ◻ *Only if problem exists* ◻ *Never*

What is your chief concern with your (or your child's) teeth? ____________________

Are you or your child sensitive or self-conscious about your teeth or smile? ◻ Yes ◻ No Explain: ____________________

Is there any unfinished care to be completed 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 instruments?	◻ 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 MARK IF THERE IS A HISTORY OF:

◻ *Clenching Teeth*	◻ *Jaw joint soreness*	◻ *Periodontal or gum treatment (If so, explain)*
◻ *Grinding Teeth*	◻ *Jaw joint clicking*	____________________
◻ *Difficulty chewing*	◻ *Jaw joint popping*	◻ *Speech problems (if so, what sounds?)*
◻ *Muscle soreness around head and neck*	◻ *Ringing in ears*	____________________
◻ *Headaches (more than normal)*	◻ *Mouth Breathing* ◻ *Awake* ◻ *Asleep*	◻ *Sleep Apnea*

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____________