Date: _____/_____/_____

Patient Name: ____

First Name Middle Initial Last Name

Address: ____

City: ___________________________ State: ____________ Zip: ____________________

Sex: M / F Birthdate: _____/_____/_____ Age: _______ SS #: _____________________

Marital Status: ☐Married ☐Divorced ☐Single ☐Partnered for ____ years ☐Minor

Occupation: _________________________________ Employer: _______________________

Home Phone #: (______) ___________________ Work #: (______) _____________________

Cell Phone #: (______) ___________________ Email:________________________________

Whom may we thank for referring you?____

IN CASE OF AN EMERGENCY, CONTACT:

Name: _______________________________________ Relationship: __________________

Home Phone #: (______) ___________________ Work #: (______) _____________________

Primary Insurance:

Policy Holder: __________________________Employer:____________________________

Relationship to patient: ____

Insurance Company: ______________________Phone Number:______________________

Group #: ______________________________ ID #: _______________________________

SS# for Policy Holder: ____________________________Birthdate: ______/______/______

Secondary Insurance (if applicable):

Is the patient covered by additional insurance? Yes / No

Relationship to patient: ____

Insurance Company: ____

Group #: ______________________________ ID #: _______________________________

Health History

Physician's Name: ____________________________ Date of last visit: _____________

Have you ever used a bisphosphonate medication commonly used for osteoporosis and/or cancer treatment? Common brand names are Fosamax, Actonel, Atelvia, Didronel & Boniva. Yes / No

Has a doctor ever recommended that you take an antibiotic prior to dental visits? Yes / No

Please indicate if you have ever tested positive or been treated any of the following:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis / Rheumatism ☐ Artificial Heart Valves ☐ Artificial Joints:

  Joint Replacement: Have you had an orthopedic **total** joint (hip, knee, elbow, finger) replacement?
  Yes / No
  Date: ______________
  If yes, have you had any complications?
  Yes / No

- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Steroid Treatments
- ☐ Cough, Persistent or Bloody
- ☐ Diabetes – Type 1 or Type 2
- ☐ Emphysema
- ☐ Epilepsy / Seizures
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Heart Problems
  - ○ Cardiovascular Disease
  - ○ Angina
  - ○ Congestive Heart Failure
  - ○ Heart Attack
  - ○ Heart Murmur
  - ○ Mitral Valve Prolapse
  - ○ Artificial Heart Valve*
  - ○ Previous Infective Endocarditis*
  - ○ Damaged Valve in Transplanted Heart*
  - ○ Congenital Heart Disease* ○ Other:
- ☐ Hepatitis – Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Kidney Disease
  - ○ Kidney Transplant ○ Dialysis
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Multiple Sclerosis
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet and/or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
  - ○ Hypothyroid ○ Hyperthyroid
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth on Head/Neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, Unexplained

Allergies

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: ______________________________

Medications

Please list all medications you are currently taking with dosage and reason for use:

____
____
____
____

For Women Only:

Are you Pregnant: Yes or No If yes, how many weeks are you?______________________________

OBGYN Name and Phone Number:____

Dental History

Reason for today's visit: ____

Former Dentist: ____________________________ City/State: ____

Date of last dental visit: __________________ Date of last dental x-rays: _______________________________

Place a mark next to the condition to indicate if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection
- ☐ Foreign objects
- ☐ Grinding and/or Clenching
- ☐ Gums swollen or tender
- ☐ Headaches ○ Migraines ○ AM ○ PM
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment (deep cleaning)
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

Are you currently experiencing dental pain? Yes / No

If so, where? ____

Do you wear dentures or partials? Yes / No

Have you ever had a serious injury to the head or mouth? Yes / No

If so, when? ____

How often do you floss? _________________________

How often do you brush? ________________________

Are you satisfied with the appearance of your teeth? Yes / No

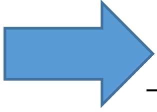
Explain if no: ____

Are you satisfied with the color of your teeth? Yes / No

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: ____

____



I have received a copy of the Notice of Privacy Practices for RVA Dental Care.

_______________________________________ ______________________

Signature Date

Authorization for Release of Information – Compound Release

Name of Patient: ____________________________ Date of Birth: ________________

RVA Dental Care is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Please indicate the entity that you approve to receive information & the information desired:

☐ Voicemail

☐ Email Communication

____

☐ Results of lab test/ x-rays

Other: ____________________

☐ Financial

☐ Medical

☐ Breach Notification

** For email communication, I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication.** Any individual(s) you wish to have access to your information:

Name Relationship Phone Number

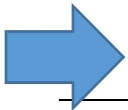
____

____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in the document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refused to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.



____ ___________

Signature of Patient of Personal Representative Date

* Description of Personal Representative's Authority (attach necessary documentation)

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to Dr. _____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____

Signature of Patient, Parent, Guardian or Personal Representative

____

Please print name of Patient, Parent, Guardian or Personal Representative

____________________________ ____________________________

Date Relationship to Patient

Financial Agreement

Uninsured Patient: By signing, I hereby certify that I am responsible for any and all services rendered. I have told and understand that payment is due at the time of service and the prices for a treatment plan that may be given to me are estimates and are subject to change during treatment, depending on the condition.

I understand that I am financially responsible for this visit and any future visits.

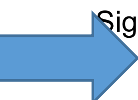
Signature of Responsible Party: _________________________________ Date: _______________

Insured Patient: By signing, I hereby certify that I (or my dependent) have insurance coverage with _______________________________________, and I have been told and understand the full breakdown of my insurance benefits prior to my appointment today. ***I understand that I am financially responsible for any deductible that may apply and all charges not paid by my insurance, for this visit and future visits.***

Signature of Responsible Party: __________________________________ Date: _______________

For all responsible parties:

- Any invoice or other outstanding balance not paid within specified terms may be subject to a finance charge of one and one half (1.5%) percent per month, an amount equal to eighteen (18%) percent annual rate.
- Any returned checks are subject to a $20.00 fee. This charge offsets our costs. In the event that this account is turned over to our attorney for collection, by signing this Financial Agreement, you agree to pay all collection fees, interest charges and processing fees in addition to attorneys' fee of 33 1/3% and court costs.
- At RVA Dental Care, we understand the importance of your time and ours. We respectfully ask that if you are unable to keep an appointment at our office, please notify us at least 24 hours prior. **If you fail to provide at least 24 hours' notice or do not show for a scheduled appointment, you will be charged a $50.00 fee.**



Signature of Responsible Party:_______________________________ Date:________________________

SOCIAL MEDIA/PHOTO CONSENT FORM

RVA Dental Care would like your permission to use images taken of you/your child to showcase extraordinary before and after smiles on our website, Facebook page and office bulletin board.

Please indicate below the following areas where you consent to the use of your/ your child's picture.

Please check all that apply.

___ RVA Dental Care Facebook/ Instagram Page
___Full face can be shown
___Teeth-only can be shown
___First name can be used

Declaration:
I grant permission for photographs of me/my child to be used in the formats indicated above.

Date: ___/___/___
Name of patient: ____
Parents/Guardian Name (if a minor):____
Signature of Parent/Guardian:____
Patient's signature (if over 18 years):____