www.DavisDentalGroup.com

14253 Midlothian Turnpike, Midlothian, Virginia 23113
Phone: (804) 320-2009 Fax: (804) 560-7250

# PATIENT INFORMATION

Today's Date _____

## Personal Information:

Patient's Legal Name: Ms. Mrs. Mr. Dr. _____

Name that you prefer we call you: _____

Date of Birth: __ __ / __ __ / __ __ __ __ SSN: __ __ __ - __ __ - __ __ __ __

Sex: __ M __ F Marital Status: ___ S ___M ___D ___W Spouse Name: _____

Address: _____ Employer:_____

_____ Work Address_____

City: _____ State _____ Zip _____ _____

Phone Numbers(circle preferred#): Home _____ Cell: _____ Work: _____

May we leave detailed messages/voicemails? Yes No

Spouse Work _____ Spouse Cell: _____

Email Address*:_____

Emergency Contact Name and Phone Number:_____

Who may we thank for sending you to our office? _____

(How did you find out about us?)

## Insurance Information:

Primary Dental Insurance: _____

Primary Insured's Name _____

Primary Insured's SSN (or ID #) _____ Group Number:_____

Employer: _____

Address of Insurance Company: (Where should we mail the claim?)

_____ Insurance Company Phone Number: _____

_____Insurance Fax Number: _____

City _____ State _____ Zip _____

## Dental History:

What is the primary reason for your appointment today?_____

When was your last dental appointment? _____ Treatment received?_____

When were your last x-rays taken?_____ What type? ____Bitewings ____ Panorex

May we request your dental records and x-rays from your previous dentist? __ Yes __ No

If so, Name of previous dentist: _____

Address:_____ Phone number: _____

* I am aware there is some level of risk that third parties might be able to read unencrypted emails

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## Medical Insurance Information:

Primary Medical Insurance: _____

Primary Insured's Name: _____ Date of Birth: _____

Primary Insured's SSN (or ID #) _____ Group # _____

Employer: _____

Address of Insurance Company: (Where should we mail the claim?)

_____

City _____ State _____ Zip _____

Insurance Company Phone Number: _____ Fax Number: _____

## Pharmacy Information:

Preferred Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone Number: _____

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# HEALTH HISTORY

Name: _____ Today's Date_____

Are you currently under a physician's care? __ Yes __ No

If yes, name and phone number of your doctor: _____ (_____)_____

Are you currently taking any medications? __ Yes __ No

Please list all prescription medications, over the counter medications, vitamins, and herbal supplements in the section provided below. Be as accurate as possible as this fill help us fully evaluate your medical condition and provide the personalized dental treatment you require. If needed, continue on the back of this page or attach list of medications.

| Medication, Herb, or Vitamin | Dosage | For what purpose are you taking it? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Do you have any allergies, or are you sensitive to, any **DRUGS** such as penicillin, aspirin, codeine, local anesthetics, etc? __ Yes __ No If yes, what are you allergic to and what type of reactions do you have?

_____

_____

Have you been hospitalized in the past 5 years? __ Yes __ No If yes, why? _____

_____

Have you ever had any of the following:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| AIDS | □ | □ | Heart Problems | □ | □ |
| Anemia | □ | □ | Hepatitis ___A___B___C | □ | □ |
| Angina | □ | □ | High Blood Pressure | □ | □ |
| Arthritis | □ | □ | HIV | □ | □ |
| Artificial Joints | □ | □ | Jaw Discomfort (TMJ) | □ | □ |
| Asthma | □ | □ | Kidney Disease | □ | □ |
| Autoimmune Disease | □ | □ | Liver Disease | □ | □ |
| Blood Disorders/Excessive Bleeding | □ | □ | Mental Health Concerns | □ | □ |
| Cancer | □ | □ | Migraines | □ | □ |
| Chemotherapy (meds) | □ | □ | Mitral Valve Prolapse | □ | □ |
| Cholesterol (High/Low) | □ | □ | Multiple Sclerosis | □ | □ |
| Cold Sores and/or Mouth Sores | □ | □ | Osteoporosis | □ | □ |
| Congestive Heart Failure | □ | □ | Pacemaker | □ | □ |
| Coumadin/Warfarin | □ | □ | Parkinson's Disease | □ | □ |
| Dementia | □ | □ | Recreational Drug Use | □ | □ |
| Dental Anxiety/ Nervous | □ | □ | Rheumatic Fever | □ | □ |
| Diabetic | □ | □ | Sexually Transmitted Disease | □ | □ |
| Eating Disorder | □ | □ | Sinus Problems | □ | □ |
| Emphysema | □ | □ | Smoker/Tobacco Use _____Years | □ | □ |
| Epilepsy or Seizures | □ | □ | Stroke | □ | □ |
| Fainting/ Convulsions/Seizures | □ | □ | Strong Gag Reflex | □ | □ |
| Fosamax®/Actonel® (meds) | □ | □ | Thyroid Problems ___Hypo___Hyper | □ | □ |
| Gastro/Reflux/Heartburn | □ | □ | Tuberculosis (TB) | □ | □ |
| Heart Murmur | □ | □ | | | |

**Do you require Pre-Medication for dental appointments? ___ Yes ___No ___ Not Sure**

Women: Are you Pregnant? ___ Yes ___ No OB Name/Phone:_____

Please explain in detail any "Yes" answers above along with any other health information you feel may be important: _____

_____

***Patient Signature (****or Guardian if under 18****)*** _____

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# RESPONSIBLE PARTY INFORMATION

| | |
|---|---|
| Name:<br>(Last, First, MI) | SSN: |
| Home Address: | Work Address: |
| D.O.B | Employer: |
| Home Phone: | Work Phone: |
| Cell Phone: | Occupation: |
| Email: | |

**** Any patient 18 years of age or older must be listed as the responsible party for the account***

## Payment Options:

Davis Dental Group is pleased to accept MasterCard, Visa, Discover Card, American Express, as well as Debit Cards. While we do not typically offer in-house financing for services, we do accept *Care Credit*, an external financing option. Please let us know if you are interested in pursuing this option and our staff will be happy to provide you with information and an application.

## Insurance Claims:

As a courtesy, Davis Dental Group will submit a claim to your primary insurance company for services rendered. All estimated co-payments and any applicable deductible will be due at time of service and will be collected at the beginning of each appointment. We will do our best to provide you with the most accurate estimate possible based on information obtained from your insurance company however, these **estimates are subject to final approval by your insurance company and could change**. Please note that any claim not paid within forty-five (45) days becomes your responsibility. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If you have any questions regarding payment on a specific claim or about your covered benefits, please speak with your human resources department or the insurance company directly.

## Cancellation Policy/Deposits:

Any appointment missed or cancelled without adequate notice may be subject to a cancellation fee of $40.00 per one-half (1/2) hour. We ask that you give us a minimum of seventy-two (72) hours notice (96 hours for Monday appointments) if you are not going to be able to make your appointment. Please note that our office is not open on Fridays and messages left with the answering service do not constitute adequate notice. You may be asked to leave a $100.00 non-refundable deposit for any appointment that is scheduled for more than 1 and ½ hours. This deposit will be applied to any co-payment amount you will owe for that appointment.

## Contractual Agreement:

I, the undersigned, understand that I am financially responsible for all charges on this account. If all charges are not paid within sixty (60) days from the date of service, I agree to pay a service charge of 2% per month, 24% per annum, on the unpaid balance. If this account is turned over for legal collections, I agree to pay all cost of collection, including, but not limited to, thirty three and one third (33.33%) percent collection costs and/or attorney's fees in addition to the balance owed.

Patient Signature (or Guardian if under 18) Date

Printed Name Relationship to Patient (if under 18)

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# HIPAA

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Davis Dental Group is required by law to maintain the privacy of protected health information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. Our Notice of Privacy Practices describes how Davis Dental Group may use and disclose PHI to carry out treatment, payment, or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you. Our current Notice is posted in our main waiting room as well as on our web site at www.davisdentalgroup.com. If you would prefer a printed copy of this Notice, please let one of our staff members know and we will be happy to provide one to you.

Your signature below indicates that you have been given an opportunity to read our Notice of Privacy Practices and have been offered a copy for your records. Additionally, your signature is required so that we may process insurance claims electronically on your behalf. Please indicate below your signature, any individual with whom Davis Dental Group may discuss your protected information including financial obligations, dental health, appointment descriptions and times and your relationship to the authorized individuals. We will not release information to anyone not listed below.

Patient Signature (or Guardian if under 18) Date

Printed Name Relationship to Patient (if under 18)

Authorized Individuals:

| Name | Relationship | Name | Relationship |
|---|---|---|---|
| Name | Relationship | Name | Relationship |

## Consent for Use of Image

From time to time, we would like to include pictures of our patients along with testimonials, before and after images of completed work, and of patient participation in our community events on our website at www.davisdentalgroup.com . Your signature below gives us permission to use your image however, you will be notified before any image is published and retain the right to request that certain images not be used. Requests should be made in writing and you must allow 90 (ninety) days for the removal of images already posted. We will do our best to use images that do not have any identifying features if that is your wish. Please feel free to ask should you have any questions.

I hereby consent to and authorize the use and reproduction, in print or electronic format, by Davis Dental Group or anyone authorized by Davis Dental Group, of any and all images taken, without compensation. All images--electronic, negatives and positives, together with the prints, are owned by DDG.

I hereby acknowledge that I have read and understood the terms of this release and that this release may be revoked at any time by providing a written request to DDG.

Patient Signature (or Guardian if under 18) Date

Printed Name Relationship to Patient (if under 18)