Thank you for choosing our team to be your dental home, we look forward to getting to know you!

Patient Information

Name (First/Middle/Last): ____ DOB: _____________

Age: ____ SSN: ____________ Address: ____

Phone: (Cell)________________ (Home)_______________ (Work)______________

Employer: ___________________________ Personal Email: __________________________________

Emergency Contact Name and Phone: ____

Insurance **** A Copy of your Dental Insurance Card and Photo ID is REQUIRED****

Policyholder Name: _______________________ DOB: _________Group #: __________ ID #: __________

Policyholder Employer: ______________________ Relationship to Policyholder: ( ) Self ( ) Spouse ( ) Child

Policyholder SSN: _____________ Dental Insurance:_____________ Secondary Insurance: ___________

Referral

How did you hear about our practice?

( ) Family____ Friend____ Co-Worker____ (Whom may we thank?):____________________________

( ) Insurance Website

( ) Advertisement (Which One): _____________

( ) Internet Search: Google____ Facebook____

( ) Other: ____

Contact Preference

I would like to receive correspondences such as appointment reminders via:

( ) Text Message on Cell Phone

( ) Email

( ) Phone Call (Cell, Home, or Work)

Dental History

1. What brought you to our dental office? ____

2. What approximate date was your last dental exam/cleaning? ____________________________________

3. Are you currently having dental pain? Yes No Where?__________________________________

4. Do you have any cosmetic concerns that you would like addressed?

   Crooked teeth Color Silver fillings Spaces Staining Other______________________

5. Are you interested in our dental whitening options? Yes No

6. Are you interested in Invisalign orthodontic treatment? Yes No

7. Do your gums ever bleed when you are brushing? Yes No

8. Do you clench or grind at night? Yes No If yes, do you wear a night guard? Yes No

9. For children 13yrs and younger: Do you have (fluoridated water supply) or (well water)? Circle one

10. Do you have/wear dentures or partials? Yes No

11. Do you take pre-medication for dental appointments? Yes No

12. Why did you leave your previous dentist? ____

13. May we call your previous office for Xrays? Yes No Office name/phone number_________________________

Financial Policy

We accept most dental insurances and are in-network providers with many local plans. If you have dental insurance, we will provide you with an **estimate** of the insurance company's expected coverage as well as your co-payment. All co-payments are due **at the time of service**. When our office receives the insurance payment and explanation of benefits, you will be responsible for any remaining balance. Any overpayments will be credited to your dental account with us or refunded to you. Our office does not guarantee that your insurance company will pay for the treatment received at our dental practice. If your claim is denied, you will be responsible for the full balance of treatment.

If you do not have dental insurance, complete payment for treatment will be required at the time of service. Overdue accounts may be turned over to a collection agency in which you will legally be responsible for any costs associated with collections i.e. court costs, attorney fees, etc.

Appointment Policy

Out of respect for the doctor, staff, and other patients' time; kindly give us a **48 hours** notice if you need to cancel or re-schedule your appointment. If **less than 24 hours** notice is given, you will be charged a **$50 fee**.

____ __________________

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

Notice of Privacy Practices Consent

I understand that under the Health Insurance Portability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Albert Family Dentistry may use or disclose my protected health information for treatment, payment, or health care operations--which means for providing health care to me, the patient, handling billing and payment, and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Albert Family Dentistry has a detailed document called the "**Notice of Privacy Practices'.** It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Albert Family Dentistry will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Albert Family Dentistry to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Albert Family Dentistry has taken action relying on this consent.

____ __________________

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

____ __________________

Relationship to Patient if signed by another party **DATE**

Notice of Deemed Consent for HIV, HBV, and HCV Testing

If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with HIV, Hepatitis B and C viruses. A Physician or other healthcare provider will tell you the results of that test. Under Virginia Code 32.1-45.1 you are deemed to have consented to the release of the test results to the person exposed. I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

____ __________________

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

____ __________________

Relationship to Patient if signed by another party **DATE**

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:__________