South River Dental P.L.L.C
(540)943-1222

Patient Information

Patient Name_____ Date*:* _____
Last, First MI (Preferred Name)

Name of Parents' if Minor-_____Patient Gender: Male/Female (circle)

Marital Status: **Mr. / Mrs. / Single/ Widowed/ (Please circle)**

Patient Social Security #*:* _____ Patient Birth Date: _____

Phone Home: _____ Work: _____(Responsible parent) Ext: _____

Cell: _____E-mail Address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____Reason for this visit: _____
Are you interested in any of these dental treatments? _____ Invisalign _____ Cosmetic Veneers _____Whitening _____ Sedation Dentistry

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/ HIV
- ☐ Alcohol Treatment
- ☐ Anemia
- ☐ Arthritis
- ☐ **Artificial Joints/Skeletal Implants, Valves**
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Bloody, Persistent
- ☐ Dizziness
- ☐ Drug Treatment
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Aches
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ **Heart Murmur**
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ **Pacemaker**
- ☐ **Pregnancy** Due date:_____
- ☐ Radiation Treatment
- ☐ Psychiatric Care
- ☐ Respiratory Problems
- ☐ Radiation Treatment
- ☐ **Rheumatic Fever**
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Thyroid Problems
- ☐ Tumors of Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Anesthesia Allergies
- ☐ Latex Allergies
- ☐ Metal Allergies
- ☐ Allergies Other
- ☐ Weight Loss (unexplained)
- ☐ _____

- **Have you ever had any complications following dental treatment? ☐ Yes ☐ No**
  If yes, please explain: _____
- **Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No**
  If yes, please explain:_____
- **Are you now under the care of a physician? ☐ Yes ☐ No • Name of Physician: _____Phone: _____**
  If yes, please explain:_____
- **Are you currently taking any medications? If yes, please list: _____**
  _____
- **Do you have any health problems that need further clarification? ☐ Yes ☐ No**
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature- Patient, Parent, Guardian

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security# _____ Birth Date-_____

Home Phone-_____Work phone-_____Ext. _____

Employer Name_____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Street Apartment #

City State Zip Code

Insurance Information

Primary Insurance Information

Name of Insured: _____ Is insured a patient? ☐ YES ☐ NO

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐**Child** ☐ **Other-_____**

Insurance Plan Name and Address: _____

_____

Insured's Birth-date Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Employer Address-_____

Secondary Insurance Information

Name of Insured: _____ Is insured a patient? ☐ YES ☐ NO

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐**Child** ☐ **Other-_____**

Insurance Plan Name and Address: _____

_____

Insured's Birth-date Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Employer Address-_____

Consent for Services-

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I understand that in the event my account becomes delinquent I agree to pay any and all collection, attorney's and court costs necessary to clear this account balance.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian/responsible party