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
- ☐ Headaches
- ☐ 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 between teeth
- ☐ Foreign objects
- ☐ Grinding and/or Clenching
- ☐ Gums swollen or tender
- ☐ Headaches
  - o Migraines
  - o AM
  - o 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

STOP-BANG SLEEP APNEA QUESTIONNAIRE

Please circle YES or NO to the following:

STOP -

1. Have you been told that you SNORE?
   YES NO
2. Do you often feel TIRED, fatigued, or sleeply during the daytime?
   YES NO
3. Has anyone OBSERVED you stop breathing during your sleep?
   YES NO
4. Do you have or are you being treated for high blood PRESSURE?
   YES NO

BANG –

1. BMI (body mass index) greater than 28?
   YES NO
2. AGE: Are you 50 years old or older?
   YES NO
3. Are you a male with a NECK circumference greater than 16 inches, or a female with a neck circumference greater than 15.5 inches?
   YES NO
4. GENDER: Male?
   YES NO

TOTAL SCORE = _____

High risk of OSA: YES 5-8
Intermediate risk of OSA: YES 3-4
Low risk of OSA: YES 0-2

Height (Feet,Inches)

Weight: (pounds)	5'0''	5'3''	5'6''	5'9''	6'0''	6'3''
140	27	25	23	21	19	18
150	29	27	24	22	20	19
160	31	28	26	24	22	20
170	33	30	28	25	23	21
180	35	32	29	27	25	23
190	37	34	31	28	26	23
200	39	36	32	30	27	25
210	41	37	34	31	29	26
220	43	39	36	33	30	28
230	45	41	37	34	31	29
240	47	43	39	36	33	30
250	49	44	40	37	34	31

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 $35.00 fee.**

Signature of Responsible Party:_____ Date:_____