BLUE RIDGE DENTISTRY

Please fill this form out completely. The better we communicate, the better we can care for you.

PATIENT INFORMATION

Patient's Name _____
LAST FIRST MIDDLE

Preferred Name _____ Date of Birth ____/____/____ Social Security# _____

Mailing Address _____
STREET CITY STATE ZIP

Home Phone # _____ Cell Phone # _____ Business Phone # _____

Email Address _____

Employer _____ Occupation _____

*If patient is a minor, give parent's or guardian's name _____

SPOUSE INFORMATION

Name _____ Date of Birth ____/____/____

Employer _____ Employer's Phone # _____

EMERGENCY INFORMATION

Person to Contact _____ Phone # _____

RESPONSIBLE PARTY

Name _____ Phone # _____

Address _____

DENTAL INSURANCE INFORMATION

Please Present Card to Receptionist

Name of Subscriber _____ Subscriber's SSN _____

Subscriber's Date of Birth ____/____/____ Subscriber's Employer _____

Dental Insurance Co. _____

Group ID# _____ Subscriber's ID# _____

Insurance Address _____

HIPAA (Privacy Act)

PLEASE WRITE NAMES OF INDIVIDUALS WHO ARE AUTHORIZED TO GET INFORMATION:

Name _____ Relationship _____

Name _____ Relationship _____

— PLEASE COMPLETE REVERSE SIDE —

MEDICAL HISTORY

Physician's Name _____ Date of last physical exam _____

List any current medical treatment, including MEDICATIONS taken at this time:

_____

_____

DO YOU HAVE ANY OF THE FOLLOWING? INDICATE WITH A (✓)

YES NO

- ☐ ☐ Allergies to drugs (please list)

_____

- ☐ ☐ Allergies to anesthetics
- ☐ ☐ Abnormal bleeding from cut or extraction
- ☐ ☐ Anemia or Blood disorder
- ☐ ☐ Arthritis
- ☐ ☐ Artificial/Joint Replacement
- ☐ ☐ Artificial Heart Valve
- ☐ ☐ Asthma
- ☐ ☐ Blood Thinners
- ☐ ☐ Currently pregnant
- ☐ ☐ Diabetes
- ☐ ☐ Excessive alcohol use / Dependency
- ☐ ☐ Eye disorders / Glaucoma
- ☐ ☐ Fainting Spells
- ☐ ☐ Hay fever or allergies in general
- ☐ ☐ Hearing loss
- ☐ ☐ Heart attack / surgery (circle one)
- ☐ ☐ Heart murmur
- ☐ ☐ Hepatitis (A, B or C - circle one)
- ☐ ☐ High blood pressure
- ☐ ☐ HIV Positive
- ☐ ☐ Illegal or recreational drug use
- ☐ ☐ Kidney Problems
- ☐ ☐ Liver Problems
- ☐ ☐ Malignancies / Cancer treatment
- ☐ ☐ Osteoporosis
- ☐ ☐ Pacemaker
- ☐ ☐ Psychiatric care/ Emotional problems
- ☐ ☐ Radiation treatments
- ☐ ☐ Rheumatic fever
- ☐ ☐ Seizure / Epilepsy
- ☐ ☐ Sexually transmitted disease
- ☐ ☐ Sinus problems
- ☐ ☐ Stroke
- ☐ ☐ Thyroid
- ☐ ☐ Tonsillitis
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcer or Colitis

DENTAL HISTORY

Chief Oral Complaint / Reason for Visit _____

Date of last Dental Exam / Dental Cleaning _____

DO YOU HAVE ANY OF THE FOLLOWING? INDICATE WITH A (✓)

YES NO

- ☐ ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ ☐ Food impaction
- ☐ ☐ Clenching or grinding
- ☐ ☐ Burning of tongue
- ☐ ☐ Frequent blisters on lips or mouth
- ☐ ☐ Pain around ear
- ☐ ☐ Unusual sounds in ear while eating
- ☐ ☐ Bad breath
- ☐ ☐ Unfavorable dental experience
- ☐ ☐ Complications from extractions
- ☐ ☐ Periodontal treatment
- ☐ ☐ Mouth breathing
- ☐ ☐ Oral habits i.e., fingernail biting, cheek biting, etc.
- ☐ ☐ Dental flossing
- ☐ ☐ Inter dental stimulators
- ☐ ☐ Water jet device
- ☐ ☐ Flouride supplements
- ☐ ☐ Dental implants
- ☐ ☐ Tobacco Use / Electronic Cigarette Devices
  If yes, how often? _____

Texture of toothbrush _____

Frequency of brushing _____

FINANCIAL POLICY FOR BLUE RIDGE GENERAL DENTISTRY

IT IS THE POLICY OF THIS OFFICE TO PROVIDE THE FINEST DENTAL CARE POSSIBLE. IN ORDER TO MAINTAIN THIS QUALITY OF CARE IT IS NECESSARY FOR US TO RECEIVE PAYMENT FOR THE SERVICES PROVIDED. THIS POLICY EXPLAINS OUR EXPECTATIONS OF PAYMENT AND THE RESPONSIBILITY OF OUR PATENTS.

Private Insurance:
We are not in network with any insurance company. Your insurance policy is an agreement between you and your insurance company. We will file your insurance for you, but you are ultimately responsible for anything your insurance does not pay. Patients are responsible for a portion of the fee at the time of service.

No Insurance Coverage:
In the event that there is no dental care coverage, options for payment must be discussed prior to services being rendered. Payment will be expected at the time of service unless prior arrangements are made.

Ultimately, payment for services provided to you in this office is your responsibility. You will receive a statement each month for any account that has a balance owed. All amounts owed are due within 30 days of the statement date. A finance charge of 1.5% per month will be charged to ALL accounts that are PAST DUE.

X Patient _____

X Parent / Guardian _____ **Date** _____