WELCOME

About You

Today's Date:

Patient Name_____

Last Name First Name Middle Initial

If under 18 years old, then please give parent or guardian name:

_____

Last Name First Name Middle Initial

What you prefer to be called_____ Male ☐ Female ☐

Birthdate:____/_____/_____ Age:_____ SS#_____-_____-_____

Mailing Address:_____

_____

City State Zip

Home Phone: (_____)_____

Cell Phone (_____)_____ Work Number (_____)_____

Email Address:_____

What is the best number to reach you during the day? _____ May we leave a message?_____

May we contact you by ☐ **Text messages** ☐ **Emails** ☐ **Both**

How were you referred to our office? _____

Employer:_____

_____

Address City/ State Zip

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name:_____

Name of Your Primary Care Physician:_____

Emergency Contact Information

Whom should we contact? _____

Relation: _____

Home phone: (_____)_____ Cell Phone: (_____)_____

Account Information

Name of person responsible for account (if different than your information):

_____Relation:_____

Billing Address: _____

SS# _____ -_____-_____ Date of Birth_____/_____/_____ Phone Number (_____)_____

*** I give my permission to discuss my appointment information or my account information with the following person(s):**

Name: _____Relation:_____

Name:_____Relation:_____

Name:_____Relation:_____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims, or if I am referred to a dental specialty practice.
- I understand that the above information was completed to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided.

I understand that payment is due at the time that services are rendered. Any anticipated insurance payment will be factored in to the amount due, but it is only an ESTIMATE. The actual amount due may exceed our calculations. You will receive notice if a balance is due, and payment will be due within 14 days of the notice unless arrangements have been made prior to treatment. Any balance not paid within 90 days from date of service will be turned over for collection action if no arrangements have been made with the business manager, and you will be responsible for any legal fees, collection fees and interest charges incurred in collecting your account.

Signed:_____Date:_____

Medical History

Constitutional					Genitourinary				
Excessive Fatigue		Yes		No	Difficult urination		Yes		No
Exercise intolerance		Yes		No	Kidney stones		Yes		No
Chills		Yes		No	Bladder Infection		Yes		No
Fever		Yes		No	Painful urination		Yes		No
Weight loss		Yes		No	Flank pain		Yes		No
Weight gain		Yes		No	Bleeding		Yes		No
Eyes									
Glaucoma		Yes		No					
Cataracts		Yes		No	**Skin**				
Blurred or double vision		Yes		No	Lesion color change		Yes		No
Redness		Yes		No	Rash		Yes		No
Pain		Yes		No	Itching		Yes		No
ENT					Redness		Yes		No
Ringing/pain in ears		Yes		No	Skin changes		Yes		No
Headache		Yes		No	Poor healing		Yes		No
Difficulty swallowing		Yes		No	**Neurological**				
Nose bleeds		Yes		No	Head injury		Yes		No
					Seizures		Yes		No
Cardiovascular					Numbness/tingling		Yes		No
Chest pain		Yes		No	Stroke		Yes		No
Heart Murmurs		Yes		No	Dizziness		Yes		No
Vascular disease		Yes		No	Tremors		Yes		No
Palpitations		Yes		No	**Hematologic**				
Irregular pulse		Yes		No	Easy bleeding/bruising		Yes		No
Fainting		Yes		No	Blood clots		Yes		No
Artificial Heart Valves		Yes		No	Blood transfusions		Yes		No
Pacemaker		Yes		No	**Endocrine**				
Dizziness upon standing		Yes		No	Heat/cold intolerance		Yes		No
					Excessive thirst/urination		Yes		No
Respiratory					**Allergic**				
Asthma		Yes		No	Reaction to food		Yes		No
Snoring		Yes		No	Reaction to environment		Yes		No
Cough		Yes		No	**Psychiatric**				
Pulmonary edema		Yes		No	Nervousness		Yes		No
Shortness of breath		Yes		No	Anxiety		Yes		No
Wheezing		Yes		No	Depression		Yes		No
Pain with a deep breath		Yes		No	Hallucinations		Yes		No
Gastrointestinal					**Muscles/Joints**				
Heartburn		Yes		No	Joint pain		Yes		No
Nausea		Yes		No	Muscle pain		Yes		No
Vomiting		Yes		No	Back pain		Yes		No
Constipation		Yes		No	Jaw/ TMD pain		Yes		No
Diarrhea		Yes		No					
Bloody/tarry stools		Yes		No					

NAME: Date:

Have you ever been diagnosed with:	Yes	No	Have you ever been diagnosed with:	Yes	No
Diabetes Type 1 or Type 2 If so, list last blood sugar and HBA1C			History of Infective Endocarditis		
High / Low blood pressure			Liver Disease		
Asthma/ COPD/ Emphysema/Breathing problems			Congenital Heart defect		
Kidney Disease			Artificial Joints		
Ulcers			Cardiovascular Disease		
Gastritis			Mitral Valve Prolapse		
Hepatitis A, B or C			Tuberculosis		
HIV			Syphilis		
HPV			Glaucoma		
Herpes, Shingles or Chickenpox			Osteoporosis		
Thyroid Disorder			Arthritis		
Sleep Apnea			Bleeding Disorder		
			Cancer		

If yes, what type of cancer and what treatments have you received (radiation, chemotherapy)_____

_____

Are you receiving or have you ever received IV Bisphosphonate treatments?_____

If so, please list dose, start/stop dates and name of physician._____

_____

Do you take or have you ever taken osteoporosis medication (ie: Fosamax, Boniva, Actonel, Reclast)?_____

If so, please give the medication name, start/stop dates and dose._____

_____

Do you take any blood thinner medications (ie: Coumadin, Jantoven, Rivaroxaben, Xarelto)?_____

If so, please give the medication name and dose._____

Do you smoke? ☐ Yes ☐ No If yes, how much? (packs or cigarettes per day) _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much?_____

Have you ever had a drug addiction? ☐ Yes ☐ No

Dr. David B. Graham, DDS and Dr. Michele L. Graham, DDS
524 Albemarle Drive, Suite 9
Chesapeake, VA 23322

REGISTRATION AUTHORIZATION

AUTHORIZATION FOR DENTAL AND/OR DIGANOSTIC TREATMENT
I, the undersigned, request treatment for either myself or my child/ward and hereby authorize Dr. David B. Graham, or Dr. Michele L. Graham (and whomever they may designate as their assistants, including hygienists) to treat me or my child/ward in ways they determine therapeutically necessary. I understand that this treatment may include tests, examinations, x-rays, fluoride treatments, administration of drugs, and medical or surgical procedures.

_____
Initial

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING
The laws of Virginia authorize health care providers to test patients for HIV antibodies when the health care provider is exposed to body fluids of a patient. In the vent of exposure, I understand that I will be deemed to have consented to testing, and consent to release test results to the health care worker who may have been exposed. Prior to testing, I will be informed and given an opportunity to ask questions.

_____
Initial

ASSIGNMENT OF BENEFITS AND AGREEMENT TO PAY FOR SERVICES
I hereby irrevocably authorize my insurance company, Medicaid or other provider of my health care benefits to pay any of my benefits directly to Dr. David B. Graham, DDS and/or Dr. Michele L. Graham, DDS in payment for their respective services rendered on my account and on the account of my child/ward. I agree to pay Dr. David B. Graham and/or Dr. Michele L. Graham for any charges not paid for by my health care benefits.

_____
Initial

AUTHORIZATION FOR RELEASE OF INFORMATION
I authorize release of any information relating to dental treatment to my insurance company. I also authorize release of any necessary information, including insurance information, to a dental specialty provider in the event that I am referred to a dental specialist for evaluation or treatment.

BROKEN APPOINTMENTS AND BILLING FEES
As a courtesy, we will contact you to remind of your next dental appointment. It is my responsibility to contact the office if I should be unable to keep any scheduled appointment. I understand that a charge will be made for broken or cancelled appointments without prior notification of 24 hours. I also understand that a repeat billing fee will be charged on accounts over 30 days past due.

_____
Initial

CERTIFICATIONS
I certify that this form has been fully explained to me and that I understand its contents. Furthermore, I permit a copy of this authorizing document to be used in place of the original.
I certify that I am the patient, the patient's parent or legal guardian and have the authority to grant this consent.
I certify that all statements and documents are true and correct. I understand that false statements or documents, or concealment of a material fact may be prosecuted under federal or state laws.

_____ _____ _____
Date Patient/Legal Guardian signature Relationship to patient

FINANCIAL AGREEMENT

The undersigned patient and/or responsible party(ies) agree that in consideration of services rendered to the patient, each of them jointly and severally, will pay and guarantee payment of the Dentist bills in accordance with the regular terms and charges of the Dentist. Any portion of the bills not covered by insurance will be payable at discharge unless other arrangements have been made in advance. It is further agreed that in the event of non-payment, that the Dentist shall have the right to proceed against the responsible party(ies) without making any demands of, or taking any action or proceeding attorney fee in the amount of THIRTY-THREE and ONE-THIRD PERCENT (33.3 %) of the amount owed.

Date_____ Patient/Legal Guardian signature _____

Dr. David B. Graham, D.D.S. / Dr. Michele L.Graham, D.D.S.

(Name of Practice)

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

_____

_____

_____

Insurance Information

Patient Name:_____

Primary Dental Insurance

Name of Insurance Carrier:_____

Subscriber's ID Number:_____

Group ID Number:_____

Insured's Name:_____

Insured's Date of Birth_____/_____/_____ Insured's SS # _____-_____-_____

Secondary Dental Insurance

Name of Insurance Carrier:_____

Subscriber's ID Number:_____

Group ID Number:_____

Insured's Name:_____

Insured's Date of Birth_____/_____/_____ Insured's SS # _____-_____-_____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

Signature:_____Date:_____

Dental History

Name: Date:

Reason for today's visit_____

Are you experiencing pain?_____ Please rate the severity of your pain: none 1 2 3 4 5 6 7 8 9 10 extreme

Is your pain improving? ☐ worsening? ☐ or remaining the same? ☐

Please indicate if you are experiencing any of the following problems:

- ☐ Discomfort, clicking or popping jaw
- ☐ Red, swollen or bleeding gums
- ☐ Sensitive tooth, teeth or gums
- ☐ Blisters/Sores in or around mouth
- ☐ Lost or broken filling (s)
- ☐ Teeth grinding
- ☐ Broken/ chipped tooth
- ☐ Stained teeth
- ☐ Other_____

Have you been told you require antiboiotic pre-medication before each dental visit? Yes ☐ No ☐ Don't know ☐

Date of Last dental exam _____/_____/_____ Were x-rays taken? ☐ Yes ☐ No

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

If not a "10", what would you like to change about your smile?_____

_____

Have you ever had periodontal (gum) surgery? _____If so, when?_____

Have you ever had a bad experience at the dentist or would you describe yourself as having dental anxiety?_____

How many times per day do you brush? _____Times a week you floss?_____

Do you drink sodas or other beverages with added sugar? _____

Do you use a fluoride toothpaste? ☐ Yes ☐ No

FOR WOMEN:

Are you taking birth control pills?_____ How many children have you had?_____

Are you pregnant or trying to become pregnant?_____ Are you nursing?_____

FOR CHILDREN:

Does Child do any of the following? ☐ Thumb/finger sucking ☐ Mouth breathing ☐ Snore

☐ Tongue thrusting/Sucking

Please list any previous surgeries and approximate year

Surgery	Year	Surgery	Year

Please list all medication **ALLERGIES**

Medication:_____Reaction_____
Medication:_____Reaction_____
Medication:_____Reaction_____

Are you allergic to penicillin? _____Are you allergic to latex? _____ Allergic to nickel?_____

Please list all medications /supplements you are currently taking

Medication Name	Dose and Frequency	When did you start taking it?	What is it for?

Update Date:_____Initials_____ Update Date:_____Initials_____
Update Date:_____Initials_____ Update Date:_____Initials_____
Update Date:_____Initials_____ Update Date:_____Initials_____
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