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: (_____)_____

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

Do you have pain in your jaw or feel jaw soreness when you wake up? ____YES ____NO

Do you feel dizzy in the dental chair or need the chair to be lowered or raised slowly? _____YES____NO

Dr. David B. Graham, DDS and Dr. Michele L. Graham, DDS
A Division of Atlantic Dental Care, PLC
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

We invite you to discuss any questions regarding our services. The best Dental health services are based on a mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit. Any portion of the bills not covered by insurance will be payable at discharge unless other arrangements have been made in advance. If account is not paid within 90 days of the date of service, you will be responsible for reasonable attorney fees, collection costs, 18% APR interest and any other expenses incurred in collecting your account. I understand the above information and guarantee this form was completed correctly to best of my knowledge and understanding.

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

Due to changes in the HIPAA laws, I,_____ ,give my permission for Dr. Graham or the staff to discuss my dental records including treatment, account/insurance information & appointments with the following person(s):

___Spouse ____Parents ____Other (please name)_____

My e-mail address is:_____

I agree that by giving my email address and text number that Graham Dental or their agents may contact me electronically. I also understand that the text messages and appt reminder emails I will receive are not encrypted.

Home Address:_____ZipCode _____

Home Telephone:_____Work_____

Cell phone_____

May we contact you by text message? ___Yes ___No

Electronic Billing

We send our Dental statements by **encrypted** email. This will not allow access if you try to open it by any other email than the one we have on file for you. We can also send it unencrypted for more accessibility (phone/tablet/other email).

Please select one of the following:

_____ I want only encrypted email sent. It will have limited accessibility
_____ I agree to allow Graham Dental to send my statement by unencrypted email
_____ Mail Statement

Signature:_____Date_____