Amelia Family Dentistry

Dentistry with a Smile

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Amelia, VA 23002

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PERSONAL DETAILS:

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_Soc.Sec.#\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_

 Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle number above that you prefer we call to communicate with you.

Work place \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In an emergency, please notify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work place \_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone\_\_\_\_\_\_\_\_\_\_

RESPONSIBLE PARTY (if different than above):

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_Relationship to patient\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc. Sec.#\_\_\_\_\_\_\_\_\_\_\_\_

DENTAL INSURANCE INFORMATION: (circle HERE if uninsured)

Name of insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate of insured\_\_\_\_\_\_\_\_\_ Soc.Sec#\_\_\_\_\_\_\_\_\_\_

Employer of insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship of insured to patient\_\_\_\_\_\_\_\_\_\_\_

Name of insurance company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have additional/secondary dental insurance? If yes, please complete the following:

Name of insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate of insured \_\_\_\_\_\_\_\_ Soc.Sec#\_\_\_\_\_\_\_\_\_\_

Employer of insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship of insured to patient\_\_\_\_\_\_\_\_\_\_\_\_

Name of insurance company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization and Financial Policy:

The information on this questionnaire is accurate to the best of my knowledge. I understand it is my responsibility to inform my dentist of any changes in my health. I authorize my insurance company to pay Amelia Family Dentistry benefits payable for services rendered. I understand it is my responsibility to monitor my insurance benefits, and that I am responsible for charges whether or not paid by insurance. I understand that I may be charged $42.00 for missed or cancelled appointments unless 24 hours advance notice given. In the event a check is returned by the bank unpaid, a charge will be added to my account. If charges are unpaid within 60 days from date of service, I agree to pay the finance charge of one and one half percent per month, and eighteen percent interest per annum on the unpaid balance. I am aware there may be a late charge on outstanding balances. In the event my account is referred to an attorney for collection, I agree to pay all costs of collection, including thirty-three and one third percent attorney’s fees on the balance owed and all court costs.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient, parent, guardian, or representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of second parent, guardian, or representative Date

MEDICAL HISTORY:

**Physician’s name** Office phone\_\_\_\_\_\_\_\_\_\_Date last seen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under medical treatment now? If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all current medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you allergic or sensitive to any of the following medications/substances?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Local anesthetic (Novocaine) | Yes/no |  | Codeine | Yes/no |  | Sedatives | Yes/no |
| Penicillin or other antibiotics  | Yes/no |  | Iodine | Yes/no |  | Aspirin | Yes/no |
| Latex  | Yes/no |  | Any metals (ex. Nickel) | Yes/no |  | Sulfa drugs | Yes/no |

Other allergies or sensitivities?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have or have you had any of the following?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Heart (surgery, disease, attack) |  Yes/no |  | Artificial joints (knee, hip, etc) |  Yes/no |  | Diabetes | Yes/no |
| Chest pain/Angina |  Yes/no |  | Bleeding problems |  Yes/no |  | Stroke | Yes/no |
| Heart murmur |  Yes/no |  | Anemia |  Yes/no |  | Hepatitis | Yes/no |
| Mitral valve prolapse |  Yes/no |  | Fainting/dizziness |  Yes/no |  | Liver disease | Yes/no |
| High/low blood pressure |  Yes/no |  | Thyroid problems |  Yes/no |  | Kidney disease | Yes/no |
| Artificial heart valve |  Yes/no |  | Stomach ulcers |  Yes/no |  | Chemotherapy/Radiation | Yes/no |
| Heart pacemaker |  Yes/no |  | MRSA |  Yes/no |  | Rheumatic Fever | Yes/no |
| High Cholesterol |  Yes/no |  | Tuberculosis |  Yes/no |  | Asthma | Yes/no |
| Arthritis/Rheumatism |  Yes/no |  | Epilepsy/seizures |  Yes/no |  | AIDS/HIV | Yes/no |

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women: Are you pregnant? Yes/no \_\_\_\_\_\_ months Nursing? Yes/no Taking birth control pills? Yes/No

DENTAL HISTORY:

Date of last dental visit \_\_\_\_\_\_\_\_\_\_Previous dentist’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was done at your last dental visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any dental problems you have now: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are your teeth sensitive to:** |  |  | **Have you ever had:** |  |
| Hot or cold?  | Yes/no |  | Dentures/partial dentures? | Yes/no |
| Sweets?  | Yes/no |  | Orthodontics/braces? | Yes/no |
| Biting or chewing?  | Yes/no |  | Periodontal/gum treatment? | Yes/no |
| Brushing or flossing? | Yes/no |  | Dental implants?  | Yes/no |
| Do your gums bleed or hurt? | Yes/no |  | A bite guard?  | Yes/no |
| Do you clench or grind your teeth?  | Yes/no |  | Serious injury to mouth or head? | Yes/no |
| Do you bite your lips or cheeks? | Yes/no |  | Previous dental infections?  | Yes/no |
| Do you smoke or chew tobacco? | Yes/no |  | Difficult extractions? | Yes/no |
| Do you have tired jaws? | Yes/no |  | Prolonged bleeding?  | Yes/no |
| Do you notice clicking or popping of jaw? | Yes/no |  | Cold sores/fever blisters | Yes/no |
| Do you have frequent headaches? | Yes/no |  | Trouble opening/closing mouth? | Yes/no |
| Are you happy with your smile? | Yes/no |  | Pain in joint, ear, side of face?  | Yes/no |