Ashburn Divine Dental

HEALTH HISTORY & REGISTRATION

DATE _____

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____

RESPONSIBLE PARTY INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____

Soc. Sec. # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____ Birthdate _____

Insurance Co. _____ PHONE _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

Primary Insurance

If you have additional dental insurance coverage, complete this for the secondary carrier

Insured's Name _____ Birthdate _____

Insurance Co. _____ PHONE _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

Secondary Insurance

Thank you for allowing us the opportunity to serve your dental needs!

Ashburn Divine Dental

NAME _____ **HEALTH HISTORY & REGISTRATION** **DATE** _____

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY

	Yes	No
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH XRAYS, Date: (16 Small Films or Panoramic)		
HOW LONG SINCE you have seen a dentist?		
How do you feel about your teeth?		
Are you having PROBLEMS now?	☐	☐
Please Describe _____		
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENT?	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐

	Yes	No
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Does food get stuck in your teeth?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐

Name of Previous Dentist?

City: State:

MEDICAL HISTORY

	Yes	No
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now? If yes, for what?	☐	☐

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

	Yes	No
Have you ever taken Fen-Phen ☐ Redux ☐ Coumadin ☐		
Do you need to premedicate?	☐	☐
Are you PREGNANT/NURSING?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Pos.	☐	☐	Cortisone treatments	☐	☐	Hepatitis	☐	☐	Rheumatic/scarlet fever	☐	☐
AIS	☐	☐	Cough (persistent)	☐	☐	High blood pressure	☐	☐	Seasonal Allergies	☐	☐
Anaphylaxis	☐	☐	Cough up blood	☐	☐	High cholesterol	☐	☐	Shingles	☐	☐
Anemia	☐	☐	Diabetes A1C _____	☐	☐	Jaw pain	☐	☐	Shortness of breath	☐	☐
Arthritis (Rheumatism)	☐	☐	Epilepsy	☐	☐	Kidney disease or malfunction	☐	☐	Skin rash	☐	☐
Artificial Heart Valves	☐	☐	Fainting	☐	☐	Liver disease	☐	☐	Spina Bifida	☐	☐
Artificial joints	☐	☐	Food allergies	☐	☐	Material allergies	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐	Mitral valve prolapse	☐	☐	Surgical implant	☐	☐
Back Problems	☐	☐	Headaches	☐	☐	Nervous problems	☐	☐	Thyroid disease or malfunction	☐	☐
Blood Disease	☐	☐	Heart murmur	☐	☐	Pacemaker/heart surgery	☐	☐	Tonsillitis	☐	☐
Cancer	☐	☐	Heart problems (please describe)	☐	☐	Psychiatric care	☐	☐	Tuberculosis	☐	☐
Chemical Dependency	☐	☐	_____			Rapid weight gain/loss	☐	☐	Ulcer/Colitis	☐	☐
Chemotherapy	☐	☐	Hemophilia (Abnormal bleeding)	☐	☐	Radiation treatment	☐	☐	Venereal disease	☐	☐
Circulatory problems	☐	☐	Herpes	☐	☐	Respiratory disease	☐	☐	Multiple Sclerosis	☐	☐

Is there any other Medical or Dental information that you feel we should know about?

FAMILY PHYSICIAN _____

PHONE _____

LAST VISIT _____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

☐ Aspirin ☐ Local Anesthetic ☐ Erythromycin ☐ Latex (balloons, gloves, etc.)

☐ Nitrous Oxide ☐ Codeine ☐ Penicillin

Are you aware of being allergic to any other medications or substances?

If yes, list:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I , or my minor child, ever have a change in health. 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 I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

Ashburn Divine Dental

DATE _____

Financial Agreement

Payments/Patient's portions are due on the same day the dental service has been rendered except extensive treatments and Invisalign.

For root canal and treatment that involves lab work, half of the payment is due on the 1st appointment and the final half is due on the last appointment.

All treatment plan costs presented are ESTIMATE only; I will be responsible for the applicable financial differences.

Every effort is made to bill my insurance directly for reimbursement; however, if they do not pay within 90 days, I will still be responsible for all the treatment fees.

I agree to pay finance charges of 1.5% per month (18% APR) on any balance 60 days past due.

If sent to collections, I agree to pay all related fees and court costs.

A fee of $50/person is charged for patients who cancel without 24-hour notice.

Payment Options: Cash, Check, Major Credit Cards, CareCredit Card (Allow you to pay over time with no interest)

_____ _____

Patient, Parent or Guardian Signature Date

HIPPA Privacy

Under my protected health insurance portablility and accountability act of 1996 (HIPPA), I understand I have the right to determine how my protected health information is used. By signing, I authorize you to use and disclose my health information to carry out treatment (direct/indirect consultation with other healthcare providers involved in my treatment), obtain payment from insurance company, and operate the practice. I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____

Patient, Parent or Guardian Signature Date

Thank you for allowing us the opportunity to serve your dental needs!