Marks Family Dentistry

Please Return This Form to Marks Family Dentistry

PATIENT REGISTRATION

Patient's Name (Please Print) _____ Preferred Name _____ Date of Birth ___/___/___

Street _____ City _____ State _____ Zip _____ Social Security Number ___-___-___

Home Phone _(_____)_____ Cell Phone _(_____)_____ Email Address _____

Patient Employed By _____ _____ Work Phone _____ Spouse or Parent _____

If spouse or parent is policy holder: Employed By _____ Social Security Number ___-___-___

Primary Insurance Company _____ Policy Holder _____ Group Number _____

ID Number (if not SSN) _____ Phone Number _(_____)_____

Secondary Insurance Company _____ Policy Holder _____ Group Number _____

ID Number (if not SSN) _____ Phone Number _(_____)_____

Person Responsible for Account _____ Relationship _____ Social Security Number ___-___-___

Spouse or Emergency Contact _____ Phone 1 _(_____)_____ Phone 2 _(_____)_____

Your dental care and account may be discussed with: _____ Relationship _____ (Person's Birthdate: Security Question to Confirm Identity) _____

Your dental care and account may be discussed with: _____ Relationship _____ (Person's Birthdate: Security Question to Confirm Identity) _____

How did you learn about our office? _____

INSURANCE

1. I am aware of Marks Family Dentistry's policies regarding dental insurance, as well as the benefits and limits of my own dental insurance policy. I have had the opportunity to review Marks Family Dentistry's statement regarding dental insurance and am aware of the following:

- Recommendations regarding dental health care are based on the professional expertise of the dentists and hygienists, and not on insurance benefits coverage.
- Marks Family Dentistry will file indemnity and PPO policies, but is not a participating provider with any insurance company. Any unpaid balance is the responsibility of the patient.
- Prior to treatment, it is the patient's responsibility to inform this office of any changes in my insurance policy or changes in my coverage within the same policy.

2. I authorize the release of medical information that may be pertinent to my dental care to any of my health care providers or insurance companies.

3. I authorize direct payment to Marks Family Dentistry of insurance benefits that are otherwise payable to me. If insurance payments are sent to me, I agree to notify Marks Family Dentistry immediately and to send the full amount to Marks Family Dentistry within five (5) business days.

PAYMENTS

4. I understand arrangements for payment must be established before dental services are provided. Payment options are: cash, check, money order, debit card or credit card. Special financing options may be available with approved credit.

5. I understand payment plans will carry a finance charge within the limits prescribed by Virginia law. In extended payment plans, a finance charge of 1 1/2% per month (18% APR) will be added after 60 days.

6. I authorize the disclosure of information regarding my relationship with this office to any party to whom disclosure is necessary to collect a fee for the services provided.

7. I understand that default on payment will subject the account to all collection fees, including, but not limited to court costs and 33.33% attorney fees or collection agency fees of the total outstanding indebtedness, (whether or not court proceedings are necessary), that may be incurred in enforcing Marks Family Dentistry's right under this agreement or under any law of the Commonwealth of Virginia.

CANCELLATION OF APPOINTMENTS OR FAILED APPOINTMENTS

8. I am aware that Marks Family Dentistry reserves the right to charge $50 per appointment hour for failed appointments and for appointments cancelled with less than 24 hours notice.

PRIVACY POLICY (HIPAA)

9. I acknowledge that I have reviewed the Privacy Policy for Marks Family Dentistry. If I do not agree to sign this acknowledgement, I agree to file my own insurance. Stated below is my reason(s) for refusal.

_____

_____

10. By signing below I certify that:

- I have completed the questions on my Patient Registration, my Medical History, and my Dental History truthfully and correctly.
- I have been given the opportunity to read and ask questions regarding the items listed above.
- **I am aware that it is my responsibility to update Marks Family Dentistry, prior to treatment, of any change in my dental or medical condition or any change in medications, either prescription or over the counter**.
- I understand my acknowledgement of (a) the accuracy of the information I have provided and (b) the policies of Marks Family Dentistry are binding on current and future services provided by this office.
- I authorize Marks Family Dentistry to discuss information regarding my dental condition and my treatment and my financial obligations to this office with the person(s) listed on this form.

Patient's Name (Please Print)

Signature of Patient / Parent / Guardian

Date

Marks Family Dentistry

9150 Dickey Drive, Mechanicsville Virginia 23116

804-746-3336

www.MarksFamilyDentistry.com

Marks Family Dentistry

Dental History

Referred by: _____

How do you rate the condition of your mouth? O Excellent O Good O Fair O Poor

Previous Dentist: _____ How long were you a patient? _____Months/Years

Date of most recent dental exam: _____ Date of most recent dental x-rays: _____

Most recent treatment other than cleaning: _____ Date of treatment: _____

I routinely see my dentist every: O 3 months O 4 months O 6 months O 12 months O Not routinely

What is your immediate concern? _____

PERSONAL HISTORY

Y N 1. Are you fearful of dental treatment? On a scale of 1 (least)--10 (most), how fearful? 1 2 3 4 5 6 7 8 9 10

Y N 2. Have you had an unfavorable dental experience? _____

Y N 3. Have you ever had complications from past dental treatment? _____

Y N 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____

Y N 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ At what age? _____

Y N 6. Do you have missing teeth that never developed or were lost due to facial trauma, fractures, or cavities?
Describe: _____

SMILE CHARACTERISTICS

Y N 7. Is there anything about the appearance of your teeth that you would like to change? _____

Y N 8. Have you ever whitened (bleached) your teeth? _____

Y N 9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____

Y N 10. Have you been disappointed with the appearance of previous dental work? _____

BITE AND JAW JOINT

Y N 11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____

Y N 12. Do you have any problems chewing gum? _____

Y N 13. Do you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____

Y N 14. Have your teeth changed in the last 5 years, become shorter; thinner or worn? _____

Y N 15. Are your teeth crowding or developing spaces? _____

Y N 16. Do you need more than one bite or squeeze to make your teeth fit together? _____

Y N 17. Do you chew ice, bite your nails, use your teeth to hold objects, or have other habits that damage teeth?

Y N 18. Do you clench your teeth in the daytime or make them sore? _____

Y N 19. Do you have any problems with sleep or wake up with headaches or an awareness of your teeth? _____

Y N 20. Do you wear or have you ever worn a bite appliance? _____

TOOTH STRUCTURE

Y N 21. Have you had any cavities within the past 3 years? _____

Y N 22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? __

Y N 23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____

Y N 24. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ____

Y N 25. Do you have grooves or notches on your teeth near the gum line? _____

Y N 26. Have you ever had broken teeth, chipped teeth, a cracked filling or a toothache? _____

Y N 27. Do you get food caught between any teeth? _____

GUM AND BONE

Y N 28. Do your gums bleed when brushing or flossing? _____

Y N 29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____

Y N 30. Have you ever noticed an unpleasant taste or odor in your mouth? _____

Y N 31. Is there anyone with a history of periodontal disease in your family? _____

Y N 32. Have you ever experienced gum recession? _____

Y N 33. Have your teeth ever become loose (without an injury),or do you have difficulty eating an apple? _____

Y N 34. Have you experienced a burning sensation in your mouth, not related to your teeth? _____

_____ _____ ____/___/_____ 5 / 4 / 2017

Patient's Name (Please Print) Patient's Signature Date

Marks Family Dentistry

Medical History

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Patient's Name (print): _____ Preferred Name: _____ Birth Date: _____

Address _____ City _____ State ____ Zip _____

Name of Physician: _____ Specialty: _____

Date of most recent physical examination: _____ Purpose: _____

How do you rate your general health? O Excellent O Good O Fair O Poor

DO YOU HAVE OR HAVE YOU EVER HAD :

Y N 1. Hospitalized for illness / injury in last 5 years

Y N 2. Had an allergic reaction to: (PLEASE CIRCLE)
Acrylic / Fluoride / Latex / Sulfa / Local Anesthetic / Penicillin / Tetracycline / Erythromycin / Aspirin / Ibuprofen / Acetaminophen / Codeine / Metals (Nickel Gold--Silver--Other _____ Nuts / Fruit / Other _____

HEART PROBLEMS:

Y N 3. Heart problems or cardiac stent within the last 6 months

Y N 4. History of infective endocarditis

Y N 5. Artificial heart valve, repaired heart defect (PFO)

Y N 6. Pacemaker or implantable defibrillator

Y N 7. High or low blood pressure

BLOOD PROBLEMS:

Y N 8. Stroke (taking blood thinners)

Y N 9. Anemia or other blood disorder

Y N 10. Prolonged bleeding due to slight cut INR>3.5

Y N 11. High cholesterol or taking statin drugs

RESPITORY OR LUNG PROBLEMS:

Y N 12. Pneumonia, emphysema, shortness of breath, sarcoidosis

Y N 13. Asthma

Y N 14. Breathing or sleeping problems (Sinus / Snoring / Sleep Apnea)

LIVER OR KIDNEY PROBLEMS:

Y N 15. Hepatitis (Type _____)

Y N 16. Liver disease

Y N 17. Jaundice

Y N 18. Diabetes (HbA1c= _____

Y N 19. Kidney disease

BONE OR JOINT PROBLEMS:

Y N 20. Orthopedic implant (joint replacement)

Y N 21. Osteoporosis / Osteopenia

Y N 22. Arthritis

DIGESTIVE PROBLEMS:

Y N 23. Stomach or duodenal ulcer

Y N 24. Digestive or eating disorders (celiac disease, gastric reflux, bulimia, anorexia)

NEUROLOGICAL PROBLEMS:

Y N 25. Alzheimer's or Parkinson's

Y N 26. MS or Paralysis

Y N 27 ADD/ADHD, piron disease

CANCER:

Y N 28. Tumor or abnormal growth

Y N 29. Radiation therapy

Y N 30. Chemotherapy, immunosuppressive medication

OTHER:

Y N 31. Rheumatic or scarlet fever

Y N 32. Thyroid, parathyroid disease, calcium deficiency

Y N 33. Hormone deficiency

Y N 34. Chronic ear infection, tuberculosis, measles, chicken pox, shingles

Y N 35. Autoimmune Disease (Rheumatoid Arthritis / Lupus / Scleroderma / Sjogren's Syndome)

Y N 36. Glaucoma

Y N 37. Contact lenses

Y N 38. Head or neck injuries

Y N 39. Epilepsy, convulsions (seizures)

Y N 40. Fibromyalgia

Y N 41. Viral infections and cold sores

Y N 42. Any lumps or swelling in the mouth

Y N 43. Hives, skin rash, hay fever

Y N 44. STI / STD / HPV

Y N 45. HIV / AIDS

Y N 46. Emotional difficulties

Y N 47. Psychiatric treatment

Y N 48. Antidepressant medication

Y N 49. Alcohol or recreational drug use

ARE YOU :

Y N 50. Aware of a change in your health in the last 24 hours (fever, chills, new cough, diarrhea)

Y N 51. Taking medication for weight management

Y N 52. Taking dietary supplements

Y N 53. Often exhausted or fatigued

Y N 54. Experiencing frequent headaches

Y N 55. A smoker, smoked previously or used smokeless tobacco

Y N 56. Considered a touchy / sensitive person

Y N 57. Often unhappy or depressed

Y N 58. Taking birth control pills

Y N 59. Currently pregnant

Y N 60. Taking dietary supplements

Y N 61. Presently being treated for any other illnesses

_____

------over------

Describe any current medical treatment, impending surgery, or other treatment that may affect your dental treatment

_____

_____

_____

All medications, supplements, and /or vitamins taken within the last two years--use an additional sheet, if needed.

Drug	Dosage	Purpose

_____ _____/_____/_____

Signature of Patient / Parent / Guardian Date

VERY IMPORTANT

Please advise us of any changes in your contact information, your medical history or any medication when changes occur.

Dentist's or Hygienist's Notes:

Entered the Patient's Dental Record: Date: _____ By: _____

Updated: _____ By: _____ Updated: _____ By: _____

Updated: _____ By: _____ Updated: _____ By: _____

Revised 10 / 1 / 2017