MEDICAL INFORMATION UPDATE

Name: _____
Last First Date of Birth

Address: _____

Home Phone: _____ Work Phone: _____

Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Physician Name:_____			
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
If yes, what condition is being treated?_____			
Date of last physical exam:_____			
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem?_____			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____
_____
_____
_____

_____
Patient Signature Date

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			

WOMEN ONLY Are you:

Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

FOR COMPLETION BY DENTIST

Comments: _____

Greene Comprehensive Family Dentistry

118 Stoneridge Drive, Suite #A
Ruckersville, VA. 22968

Patient Information

Patient Name: _____

Address:_____

City:_____ State:_____ Zip:_____

Home Number: ( ) _____ Work Number: ( ) _____

Cell Number: ( ) _____ Email: _____

Patient SS#: _____ DOB: _____

Drive License #: _____ State of Issue: _____

Financially Responsible Party

Name: _____ Patient Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: ( ) _____ Work Number: ( ) _____

Cell Number: ( ) _____ Email: _____

Insurance Information

Policy Holder: _____ Patient Relation: _____

Policy Holder's DOB: _____ Policy Holder's SS#:_____

Policy Holder's Employer:_____ Work Phone Number: ( )_____

Insurance Company:_____ Phone Number: ( )_____

Group #:_____ Subscriber ID #:_____

Emergency Contact Information

Emergency Contact:_____ Phone Number: ( )_____

Address:_____

City:_____ State:_____ Zip:_____

GREENE COMPREHENSIVE FAMILY DENTISTRY

PATIENT FINANCIAL RESPONSIBILITY

I _____ hereby assign to Greene Comprehensive Family Dentistry all payments for all services rendered to myself and/or my dependents. I understand that I am responsible for payment of any amount not paid by my insurance company and that billing my insurance company is a courtesy and not an obligation of this office.

I acknowledge that any insurance claims pending beyond thirty (30) days are my responsibility. I will immediately pay the balance if the account balance is more than thirty (30) days past due. I understand that if I make a payment and Greene Comprehensive Family Dentistry thereafter receives payment from my insurance company, I will be reimbursed. I understand that if my account is still outstanding after sixty (60) days from the date of service(s), my account may be referred to a collection agency or an attorney for collection unless prior agreements are made.

This office participates as "Dental Providers" for **Anthem, Cigna Radius, Delta Dental Premier, Guardian, MetLife** and **United Concordia.** If you have dental insurance with companies other than those listed above, you will be responsible for your co-payment **TODAY** according to your dental insurance plan. We will submit today's visit to your insurance company. Also that all estimates for co-payment are **estimates** you are responsible for what your insurance does not pay.

- I agree to pay interest on the total paid monthly balance at the rate of **18.00% APR**, such interest to begin if the **account is thirty (30) days past due** and calculated from the date of service.
- I agree to pay all costs of collections, including, but not limited to, thirty-five percent (35%) collection fees and attorney fees of thirty-three percent (33%), but not less than $200.00, regardless if suit is filed or not, as well as, all court costs.
- I authorize my employer to release all information regarding employment and salary verification.
- I understand Greene Comprehensive Family Dentistry **DOES NOT** accept postdated checks.
- I understand Greene Comprehensive Family Dentistry **DOES NOT** accept payment plans and payment is expected at every appointment unless otherwise stated.
- Broken, missed, or canceled appointments without 24 hours prior notification will be charged a missed appointment fee of $75.00.
- **I will pay any expected deductible and co-insurance amounts today and at each future office visit.**

We are a medical practice and as such we will ask you to complete a Health History Form. We will ask you for updates of your personal and medical information. Please notify our staff if there is a change in your health. Your health information is important to us and to your treatment here. Your cooperation in completing this information is appreciated.

THERE WILL BE A FEE OF $35.00 FOR ALL RETURNED CHECKS

_____ _____ _____

Print Name (Patient) Signature of Responsible Party Date

GREENE COMPREHENSIVE FAMILY DENTISTRY

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law.
You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Practice is a member of statewide Prescription Monitoring Program.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

I give my permission to discuss my treatment and or billing information with: _____

Relationship to patient (check one):

❽ Spouse ❽ Parent ❽ Child ❽ Grandparent ❽ Grandchild ❽ Legal Guardian

❽ Attorney (or representative) of patient ❽ Other: _____

This HIPAA Consent was signed by: _____ _____

Signature of patient or guardian — Printed name of same

Relationship to the patient (if other than patient):_____ _____

Please print — Today's Date

Signature of practice representative:_____