JAMES RIVER DENTAL

Patient Information

All information is confidential

Patient First Name: _____ M.I. ___ Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ May we send you text messages? (Circle) **Yes No**

Home Phone: _____ Birth Date: _____ Sex: (Circle) **Male Female** S.S. #: _____

E-Mail Address: _____ Employer: _____ Work Phone: _____

Marital Status: (Circle) **Minor / Single / Married / Divorced / Widowed / Engaged / Domestic Partnership**

Spouse's Information - Name: _____ Phone #: _____ SS#: _____ DOB: _____

May we share your protected health information with your spouse? (Circle) **Yes No**

May we share your account information with your spouse? (Circle) **Yes No**

May we link your account with your spouse's? (Circle) **Yes No**

Relative or Friend (Not at the same address): _____

Relationship to patient: _____Cell Phone: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

May we share your protected health information with this person? (Circle) **Yes No**

May we share your account information with this person? (Circle) **Yes No**

Parent/Guardian Information (If patient is a minor)

Mother's information- First Name: _____ M.I. ___ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ S.S.#: _____Birth Date: _____

E-Mail Address: _____Employer: _____ Work Phone: _____

Father's information- First Name: _____ M.I. ___ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ S.S. #: _____Birth Date: _____

E-Mail Address: _____Employer: _____ Work Phone: _____

*I understand that by signing below I am financially responsible for the patient listed at the top of this form and that I have read and understand the *Payment/ Co-pay section on page two of this form.*

X _____**Date:** _____

← **OVER** →

Dental History:	Yes	No	Unknown
Have you ever had a full-mouth series of x-rays or an x-ray that went all around your head (panoramic x-ray)? If yes, how long ago? _____			
Do you experience jaw popping or clicking?			
Do you grind your teeth? If yes, circle: While sleeping / While awake			
If you grind your teeth, does it cause jaw pain?			
Have you ever had trouble getting numb?			
Have you ever had an allergic or adverse reaction to dental anesthetic?			
Do you have anxiety/ fear of the dentist/ dental office?			
Do you prefer to have nitrous oxide (laughing gas) during your procedure?			
Please tell us anything else you feel is important to your dental care:			
Denture/ Partial Patients:			
Approximately how old is your current denture/ partial?			
What complaints, if any, do you have with your current denture/ partial?			

How did you hear about us? (Please circle only one): Insurance List TV ad Google/Bing/Yahoo Billboard Phone Book Drove by/ Live close Friend/ Relative (Name): _____ other: _____

***Payment/ Co-Pay-** I understand payment is due in full the day services are provided. I understand the office does not offer any payment plans other than through a finance company (Care Credit). I understand all fees are due in full on the date of service, (even if more than one appointment is required to finish the procedure, i.e. dentures, partials, crowns, etc.). Payment can be made by cash, check, and credit / debit card or financing through Care Credit, with approved credit. I agree that if collection problems arise, I am liable for all collection fees, including attorney fees, court costs and late charges. I understand that quotes/ treatment plan amounts with insurance are only an estimation and I am ultimately responsible for all fees incurred for the patient listed on page one of this form.

Consent- I give my consent to be seen by the doctor. If I elect treatment, I consent for the work to be done. I understand that during the course of the procedure(s) unforeseen conditions may arise which necessitate procedures other than contemplated. I am aware there may be additional charges associated with the new treatment. I understand that the treatment plan/options I was given is just an estimation and the actual amount of my treatment could differ from the amount originally quoted. I trust that the doctor has given me the closest possible estimation and I will be informed of any additional costs that are incurred.

HIPAA- I have reviewed and acknowledged the Notice of Privacy Practices for the office and consent for use and disclosure of health information. I have notated on page one of this form whether or not the office may share my protected health information and account information with my spouse (if applicable) and one other person I have listed. I understand if I wish for the office to share my protected health or account information with anyone other than my spouse or the other person I have listed on page one, I will need to complete and sign a separate form.

I have read and completed all items in good faith and as accurately as possible. I understand this form will remain effective until a new "Patient Information" form is completed and signed for the patient listed on page one.

Patient/Guardian Signature _____ Date _____