MIDLOTHIAN
Dental Center

Welcome to our office! In order for us to render the proper dental treatment to you, please be kind enough to answer the following questions as accurately and completely as you can. If you are unsure someone here at MDC will be happy to assist you if needed. Thank you!

PATIENT INFORMATION:

Name:_____ Age:_____ Date:_____
Address:_____ Date of Birth:_____
City/Zip: _____ H.Phone:_____
Gender:_____Marital Status:_____W Phone:_____
Height:_____ Weight:_____ Email:_____
SSN:_____Referred by:_____

RESPONSIBLE PARTY

Name:_____ Birthdate:_____
Gender:_____ Marital Status:_____ SSN:_____
Address:_____ H.Phone:_____
City/Zip: _____ W.Phone:_____

EMPLOYMENT INFORMATION

The following is for: [ ] the patient [ ] the person responsible for payment
Employer Name:_____
Address:_____

INSURANCE INFORMATION

Primary
Name of Insured:_____ Birthday:_____
Insured's Address:_____
ID #:_____ Group #:_____
Insured's Employer Name:_____
Patients relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other
Insurance Plan Name & Address:_____
_____

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1. Reason for your visit:_____
2. When was your last dental visit?_____
3. How often do you brush & floss?_____
4. Do you notice any odor when you floss?_____

DENTAL HISTORY:

1. Do your gums bleed while brushing? **Y/N**
2. Do your gums bleed while flossing? **Y/N**
3. Do you feel pain on any of your teeth? **Y/N**
4. Are your teeth sensitive to hot/cold? **Y/N**
5. Does food get caught between your teeth? **Y/N**
6. Do your teeth feel loose? **Y/N**
7. Do you have any sores/lumps in your Mouth? **Y/N**
8. Have you experienced any of the following:
   a. Jaw clicking **Y/N**
   b. Pain in your jaw **Y/N**
   c. Difficulty opening/closing **Y/N**
   d. Difficulty in chewing **Y/N**
9. Have you had any head, neck or jaw injuries? **Y/N**
10. Do you have frequent headaches? **Y/N**
11. Do you clench or grind your teeth? **Y/N**
12. Have you ever had:
    a. Orthodontic treatment? **Y/N**
    b. Oral surgery? **Y/N**
    c. Gum treatment? **Y/N**
    d. Your teeth ground or the bite adjusted? **Y/N**
    e. Worn a night guard? **Y/N**
13. Are you satisfied with the appearance & color of your teeth? **Y/N**

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

1. Are you in good health? **Y/N**
2. Have there been any changes in your General health within the past year? **Y/N**
3. Are you under the care of a physician? **Y/N**
4. Date of last physical exam:_____
5. Physician's Name:_____
   _____
6. Have you ever been hospitalized for any Surgical operations or serious illness? **Y/N**
7. Are you taking any medications? **Y/N**
   _____
   _____
   _____
   _____
8. Have you had any abnormal bleeding? **Y/N**
9. Do you bruise easily? **Y/N**
10. Have you ever required a blood transfusion? **Y/N**
11. Have you had a recent weight loss? **Y/N**
12. Do you smoke or use other tobacco? **Y/N**
13. Do you have any chemical dependency? **Y/N**
14. Are you wearing contact lenses? **Y/N**
15. Do you have any disease, conditions or problem not listed about that you think I should know about?_____ **Y/N**

WOMEN ONLY:

1. Are you pregnant or think you may be? **Y/N**
2. Are you nursing? **Y/N**
3. Are you taking birth control? **Y/N**

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CIRCLE if you have/had any of the following:

Aids	Cortisone Treatment	Hepatitis	Rheumatic Fever
Anemia	Cough(persistent)	High Blood pressure	Scarlet Fever
Arthritis	Cough up blood	HIV positive	Shortness of breath
Artificial heart Valves*	Diabetes	Jaw pain	Skin Rash
Artificial Joints*	Epilepsy	Kidney Disease	Stroke
Asthma	Fainting	Liver Disease	Swelling of feet/ankles
Back Problems	Glaucoma	Mitral Valve Prolapse	Thyroid Problems
Blood Disease	Headaches	Nervous Problems	Tobacco Habit
Cancer*	Heart Murmur	Pacemaker	Tonsillitis
Chemical Dependency	Heart Problems*	Psychiatric care	Tuberculosis
Chemotherapy*		Radiation Treatment	Ulcers
Circulatory Problems	Hemophilia	Respiratory disease	Venereal Disease

****Please describe if you circled these conditions:

_____

_____

_____

ALLERGIES:

Aspirin	Penicillin
Barbiturates (sleeping pills)	Sulfa
Codeine	other:_____
Local Anesthetic	_____
Latex	_____

The above information is accurate & complete to the best of my knowledge. I will not hold my dentist or any member of Midlothian Dental Center staff responsible for any errors or omissions that I may have made in the completion of this form.

I hereby authorize Central Virginia Dental Care, PLC DBA Midlothian Dental Center to release the information requested to the insurance company named herein. I hereby assign payment directly to the above-named dentist of benefits otherwise payable to me. I understand that regardless of insurance coverage, I am financially responsible for all charges incurred. I agree that in the event my account must be submitted to an attorney or other agency for collection, I am responsible for all attorney's fees, collection fees, court costs and interest.

PLEASE BE ADVISED THERE WILL BE A $35 CHARGE FOR ANY APPOINTMENTS CANCELED WITH IN LESS THAN 2 BUSINESS DAYS NOTICE

Signature:_____ Date:_____

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Dental Center

Acknowledgement of Receipt of Notice of Privacy Practices
*You may refuse to sign this acknowledgement

I, (please print)_____, have received a copy of this office's Notice of Privacy Practices.

Signature:_____ Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____

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DISCLOSURES TO FAMILY AND FRIENDS

I, _____, give consent for my health care
(please print your name)

Information to be given to the following people in person and by phone:

NAME	PHONE	RELATIONSHIP

CONSENT IN CASE OF AN EMERGENCY

I, _____, give consent for Midlothian Dental Center

to contact the following people in case of an emergency:

NAME	PHONE	RELATIONSHIP

I GIVE PERMISSION FOR MIDLOTHIAN DENTAL CENTER TO CONFIRM APPOINTMENTS/LEAVE A MESSAGE ON MY:

CELL_____
HOME_____
WORK_____

SIGNATURE_____ **DATE**_____