



First Name: _____ Last Name: _____

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

Home Phone: _____ Work Phone: _____

Cell: Phone: _____ Pager: _____

Email: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Date of Birth: _____ Social Security #: _____

Employer: _____ Employer Address: _____

Employment Status: Full Time Part Time Retired Student Status: Full Time Part Time

Name of Emergency Contact: _____ Emergency Contact Phone: _____

Patient Preferences

Do you prefer Morning Appointments? Afternoon Appointments?

What's your preferred method of us contacting you? Phone Email

How did you hear about us?

- Referred by a friend or relative If yes, who? _____
- Our Website (www.lansdownefamilydental.com)
- Facebook, Group on, or other social media
- Print Advertising
- Other: _____

Patient Responsibility

Who is responsible for your accounts? Self Spouse Parent Other

If not your self: Responsible party's name: _____ Date of Birth: _____

Employer: _____ Work Phone: _____

Social Security #: _____

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

Insurance

Do you have Dental Insurance? No Yes Insurance Co Name: _____

Subscriber: _____ Relationship to Patient: Self Spouse Parent Other

Subscriber's Employer: _____ Social Security #: _____

*Your smile brightens
our day!*

DENTAL HISTORY

1. Reason for your visit? _____
2. When was your last dental visit? _____
3. How often do you brush? _____
4. Do you use a manual or electric tooth brush? _____
5. What texture brush do you use? _____
6. Do your gums bleed? Yes No
7. Do you floss? Yes No
8. Do your gums bleed when you flossing? Yes No
9. Do you feel pain to any of you teeth when brushing or flossing? Yes No
10. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? Yes No
11. Have you notice any loosening of teeth Yes No
12. Does food tend to become caught between your teeth? Yes No
13. Do you have any sores or lumps in your near you mouth? Yes No
14. Have you experienced any of the following problems in your jaw?
 - a. Clicking? Yes No
 - b. Pain (joint, ear, side of face) Yes No
 - c. Difficulty in opening or closing? Yes No
 - d. Difficulty in chewing? Yes No
15. Have you had any head, neck, or jaw injuries? Yes No
16. Do you have frequent headaches? Yes No
17. Do you bite your lips or cheeks frequently? Yes No
18. Have you ever had:
 - a. Orthodontic treatment (Braces or Invisalign) Yes No
If Yes What Age? _____
 - b. Oral surgery? Yes No
 - c. Gum Treatment? Yes No
 - d. Your teeth ground or the bite adjusted? Yes No
 - e. Worn a bite plane or other appliance? Yes No
19. Are you satisfied with the appearance of your teeth? Yes No
20. Is there anything about having dental treatment that bothers you? Yes No
If Yes, Please explain

21. If there's anything you'd like to improve regarding your smile what would that be?

To the Best of my Knowledge, the questions on this form have been accurately answered. I understand that proving incorrect information can be dangerous to my or patient health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____
DATE _____

*Your smile brightens
our day!*

**ACKNOWLEDGEMENT OF
PRIVATE PRACTICES**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly.
2. Obtain payment from third-party payers for my health care services.
3. Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

1. Pursuant to Virginia Law 32.1-54.1 Any patient who exposes a health care provider or his employee/agent to body fluid in a manner which may transmit the human immunodeficiency virus (HIV), Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis B and C testing and provider who exposes a patient to body fluid in the above stated manner.

Signature: _____ Date: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement

For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy due to the following reason:

- The Patient refused to sign
- Communication barriers
- Emergency

situation

*Your smile brightens
our day!*

FINANCIAL POLICY

It is the goal of our practice to provide not only the finest care available, but also to provide financial services that do not cause undue hardships. Patients will be scheduled for treatment after financial arrangements are made with our financial department regarding all treatment. **OUR FINANCIAL DEPARTMENT IS AVAILABLE TO ANSWER ANY QUESTIONS YOU HAVE.**

Our office requires a 24 hour notice if you are not able to make your appointment. If we do not receive this notice, a fee will be charged to your account.

X-ray Requirements—We pride ourselves in delivering the highest standard of care; therefore, complete diagnostic x-rays are necessary. We require a complete series of x-rays on new patients and patients who have not been to see us on a regular basis. If you have had this series done with another dentist in the past three years, we ask that you bring them with you on your initial visit. **IF YOU DO NOT HAVE THEM OR ARE NOT ABLE TO RETRIEVE THEM FROM YOUR PRIOR DENTIST BEFORE YOUR APPOINTMENT WITH US, WE WILL NEED TO TAKE X-RAYS AND BILL YOU.**

Insurance policy—The patient is always expected to pay his/her portion at the time of service, including co-pay and deductibles. As a courtesy to all of our patients with insurance, we will file dental services with your insurance company. The normal time allowed for insurance response is 30 days. Any charges remaining on your account after your insurance pays are ultimately your responsibility. When the office quotes insurance co-pays, this is an **estimate** only.

Payment Policy—Our office requires payment in full for all services rendered at the time of visit. Payment plans are available and are arranged through our financial department to assist our patients.

Collection policy—If your account becomes delinquent and no financial arrangements have been made, you will be responsible for legal fees, and any other expenses incurred in collecting your account balance. All work must be paid in full at the time of service once your account has been satisfied with the attorney.

AUTHORIZATIONS FROM PATIENT

I authorize Lansdowne Family Dental to perform any necessary services needed during diagnosis and treatment. I also authorize the release of any required information to outside health practitioners and for the purpose of processing insurance claims.

I understand that my insurance policy is a contract between my insurance company and me and that I am responsible to Lansdowne Family Dental for all fees.

I authorize and request my insurance company (if applicable) to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual billed services and that I am responsible for the remaining balance.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature of Patient/Parent/Guardian of Minor _____

Date _____

*Your smile brightens
our day!*

MEDICAL HISTORY

Patient Name _____ Birth date _____

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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____
 Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
 Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
 Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
 Do you take, or have you ever taken, Phen-Fen or Redux? Yes No _____
 Are you on a special diet? Yes No _____
 Do you use tobacco? Yes No _____
 Do you use controlled substances? Yes No _____

Women: Are you: Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If other, please explain: _____

Do you have, or have you had, any of the following? (Circle all that apply)

AIDS/HIV Positive	Congenital Heart	Hay Fever	Lung Disease
Alzheimer's disease	Disease	Heart attack/Failure	Mitral Valve Prolapse
Anaphylaxis	Convulsions	Heart Murmur	Pain in Jaw Joints
Anemia	Medicine	Heart Pace Maker	Sickle Cell Disease
Angina	Diabetes	Heart Trouble/Disease	Sinus Trouble
Arthritis/Gout	Drug Addiction	Hemophilia	Spina Bifida
Artificial Heart Valve	Easily Winded	Hepatitis A	Stomach Disease
Artificial Joint	Emphysema	Hepatitis B or C	Stroke
Asthma	Epilepsy or Seizures	Herpes	Swelling of Limbs
Blood Disease	Excessive Bleeding	High Blood Pressure	Thyroid Disease
Blood Transfusion	Excessive Thirst	Cortisone	Tonsillitis
Breathing Problem	Fainting	Hives or Rash	Tuberculosis
Bruise Easily	Spells/Dizziness	Hypoglycemia	Tumors or Growths
Cancer	Frequent Cough	Irregular Heartbeat	Ulcers
Chemotherapy	Frequent Diarrhea	Kidney Problems	Veneral Disease
Chest Pains	Frequent Headaches	Leukemia	Yellow Jaundice
Cold Sores/Fever	Genital Herpes	Liver Disease	
Blisters	Glaucoma	Low Blood Pressure	

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dentist of any changes medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____

*Your smile brightens
our day!*