Harvey Dentistry, NRV, PC
4664 Lee Hwy • PO Box 2143
Dublin, Virginia 24084
540-674-8891 (p)
nrv@blueridgedentalgroup.com

Patient Information (Confidential)

Date _____

Name _____ DOB _____ SS# _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____ Home Phone _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient Employer _____ Work Phone _____

Spouse Name _____ Alternate Phone _____

Person to contact in case of Emergency _____ Phone _____

Dependant _____ DOB _____ SS# _____

Dependant _____ DOB _____ SS# _____

Dependant _____ DOB _____ SS# _____

Signature of Patient/Parent/Guardian _____

Responsible Party

Self (same as above) ❑ Yes ❑ No

Name of Person Responsible for this account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

DOB _____ SS# _____ Phone _____

Is this person currently a patient in our office? ❑ Yes ❑ No

Signature of Patient/Parent/Guardian _____

Insurance Information

Name _____ DOB _____ SS# _____

Insurance Company _____

Address _____

Group Plan Name _____

Policy # _____

Are you covered by Secondary Insurance? If so please list:

Name _____ DOB _____ SS# _____

Insurance Company _____

Address _____

Group Plan Name _____

Policy # _____

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Financial Policies

1. I understand that I am responsible for payment of all products and services provided to me or my dependents by this Blue Ridge Dental Group office.
2. I understand I may be charged a $50 fee for any broken appointment without 48 hour notice.
3. I understand that consistently broken appointments will require a credit card reservation in order to secure my next appointment.
4. I understand that $100 deposits are required to secure appointment times for periods longer than one hour.
5. I understand I will be charged a $25 processing fee for returned checks.
6. I understand there may be a 1.5% per month finance charge on all accounts over 30 days past due.
7. I understand if my account is not paid within 90 days of treatment it may be turned over to a collection agency or the office attorney and I will be responsible for all collection fees and court costs associated with my delinquent account .
8. We accept credit cards, checks and cash unless prior financial arrangements have been made for qualified individuals.

I have been give the opportunity to ask questions and I agree to the Financial Policies of this office.

Signature of Patient/Parent/Guardian_____ Date _____

Release and Assignment

I give this office permission to take images of my teeth, mouth and face and use them to aid in educational purposes, internal marketing and submission to insurance companies to help the patient get reimbursement and treatment approval, using both electronic and paper images, as needed and requested by the insurance companies.

I understand that Insurance is a contract between myself and my insurance company. Insurance is filed as a courtesy to patients of this office. Insurance estimates are estimates only. Although this office will do its best to help, this office will not be involved in insurance disputes.

HIPPA Consent Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practice: You have the right to read our notice of privacy practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we ma y make of your protected health information.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice of privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: you will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contract person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue to treat you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and the notice of privacy practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities, and health care operations.

Signature _____ Date _____

If this consent is signed by a personal representative, parent or guardian on behalf of the patient, complete the following:

Personal Representatives Name_____ Relationship to Patient _____

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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 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 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 yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

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 dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Dental Questionnaire

Last First Middle Nickname Date

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? ☐ Yes ☐ No
2. Have you ever had any serious trouble associated with previous dentistry? ☐ Yes ☐ No
3. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
4. Date of last dental visit? _____ Previous Dentist _____
5. Have you ever been treated for periodontal disease (gums, pyorrhea, trench mouth)? ☐ Yes ☐ No
6. How often do you brush? _____ Brush is: ☐ Soft ☐ Medium ☐ Hard
7. Do you have or have you ever had any of the following?

MOUTH			TEETH			
Bleeding, sore gums	☐ Yes	☐ No	Loose Teeth	☐ Yes	☐ No	
Unpleasant taste/bad breath	☐ Yes	☐ No	Sensitive to hot	☐ Yes	☐ No	
Burning tongue/lips	☐ Yes	☐ No	Sensitive to cold	☐ Yes	☐ No	
Frequent blisters, lips/mouth	☐ Yes	☐ No	Sensitive to sweets	☐ Yes	☐ No	
Swelling/lumps in mouth	☐ Yes	☐ No	Sensitive to biting	☐ Yes	☐ No	
Ortho treatments (braces)	☐ Yes	☐ No	Food Impaction	☐ Yes	☐ No	
Biting cheeks/lips	☐ Yes	☐ No	Clenching/grinding	☐ Yes	☐ No	
Clicking/popping joint	☐ Yes	☐ No	when?	☐ Night	☐ Day	☐ Both
Difficult opening or closing jaw	☐ Yes	☐ No	Shifting in bite	☐ Yes	☐ No	
			Change in bite	☐ Yes	☐ No	

8. Do you use the following?

Brush	☐ Yes	☐ No	Dental Floss	☐ Yes	☐ No
Fluoride Rinse	☐ Yes	☐ No	Other _____		

These are the things that are important to me about my dental health: _____

_____

_____

What do you fear most about dental care? _____

_____

Circle One:

1. My Mouth Is:
   a) very comfortable
   b) moderately comfortable
   c) uncomfortable
2. I
   a) think the appearance of my mouth is excellent
   b) am satisfied with appearance of my mouth
   c) am dissatisfied with the appearance of my mouth
3. I
   a) will do anything to keep my natural teeth
   b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them.
4. I
   a) have set goals for my oral health with a previous dentist
   b) want to set goals concerning my dental health
5. I
   a) have always done the best that was recommended for my dental health
   b) have not done what dentists have recommended to me
   c) rarely go, and don't care much about having any dental work completed
6. I
   a) have put dentistry for myself and family high on my priority list
   b) put dentistry for myself and my family low on my priority list
   c) Dentistry is on my list, but it's hard to find
7. I think my present state of dental health is
   a) Excellent
   b) Good
   c) Poor

What are some questions about dentistry and oral health that you have never had adequately answered? _____

_____

_____