



**Gregory T. Harvey, DMD, PC**  
1618 W. Main Street  
Salem, Virginia 24153  
540-389-0720 (p)  
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## ***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***

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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***

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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***

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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 may 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.

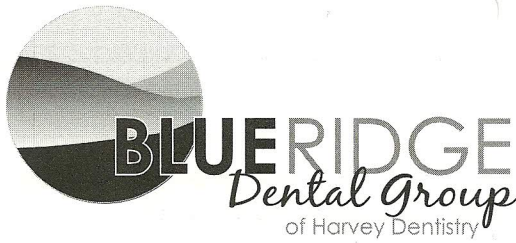
Right to Revoke: you will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contract person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received 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 <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No          | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No  | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> 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**

- Bleeding, sore gums  Yes  No
- Unpleasant taste/bad breath  Yes  No
- Burning tongue/lips  Yes  No
- Frequent blisters, lips/mouth  Yes  No
- Swelling/lumps in mouth  Yes  No
- Ortho treatments (braces)  Yes  No
- Biting cheeks/lips  Yes  No
- Clicking/popping joint  Yes  No
- Difficult opening or closing jaw  Yes  No

**TEETH**

- Loose Teeth  Yes  No
- Sensitive to hot  Yes  No
- Sensitive to cold  Yes  No
- Sensitive to sweets  Yes  No
- Sensitive to biting  Yes  No
- Food Impaction  Yes  No
- Clenching/grinding  Yes  No
- when?  Night  Day  Both
- Shifting in bite  Yes  No
- Change in bite  Yes  No

8. Do you use the following?
  - Brush  Yes  No
  - Fluoride Rinse  Yes  No
  - Dental Floss  Yes  No
  - Other \_\_\_\_\_  Yes  No

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
    - a) Excellent
    - b) Good
    - c) Poor

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