



Harvey Dentistry, SML, PC
12925 Booker T. Washington Hwy • Ste 202
Hardy, Virginia 24101
540-721-2448 (p)
sml@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 _____



Medical History

Last _____ First _____ Middle _____ Nickname _____ Date _____
 Physician _____ Office Phone _____ Date of Last Exam _____

- | | |
|---|---|
| <p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
 If yes, please explain _____</p> <p>3. Are you taking medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No
 If yes, what medication(s) are you taking? _____</p> <p>4. Have you ever taken Fen-Phen/Redux? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you have or have you had any of the following?</p> | <p>10. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Are you allergic to or have you had any reactions to the following?</p> <p>Local Anesthetics (e.g. Novocaine) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or any other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any Metal (e.g. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex Rubber <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other (Please list) _____</p> <p>12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Women Only:</p> <p>a) Are you pregnant or think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|---|

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: _____

Authorizations and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____
 Signature of patient (or parent/guardian if minor) _____ Date _____

Doctor's Comments _____

Dental Questionnaire of Blue Ridge Dental Group – SML Office

When was your last dental checkup _____? When did you last have x-rays made?

1. Do you have any pain or sensitivity in your teeth because of heat, cold or sweets? Y N
2. Do you have any pain or sensitivity in any part of the mouth or in any tooth while biting or chewing? Y N
3. Does food catch between your teeth? Y N

4. Do you chew on both sides of your mouth? Y N
5. Do you bite your lips or cheeks frequently? Y N
6. Do you clench or grind your teeth during the day? Y N
7. Have you been made aware of clenching or grinding your teeth during the night? Y N

8. How often do you brush your teeth? _____
9. If you floss, how often? _____
10. Do you avoid any part of the mouth while brushing? Y N
11. What toothpaste do you use? _____
12. How often do you have your teeth professionally cleaned? _____
13. Do your gums feel irritated, tender or swollen? Y N
14. Do you ever have bleeding from your gums? Y N
15. Have you ever had periodontal (gum) treatment either by a general dentist or periodontist? Y N
16. Have you ever had any orthodontic treatment (braces)? Y N
17. Do you have ringing or pain in your ears? Y N
18. Do you have difficulty opening or closing your jaw? Y N
19. Do you have clicking or popping in your jaw joints? Y N
20. Have you ever been treated for temporomandibular disease (TMJ or TMD)? Y N
21. Do you have frequent headaches? Y N

22. Do you like your smile? Y N
23. Would you like to keep your natural teeth for a lifetime? Y N
24. Have you ever done a dental oriented diet analysis? Y N
25. Is there anything we need to know about you that will help us make your experience here more successful?