Henritze Dental Group

1656 N Main St | Rocky Mount, VA 24151 | (540) 483-3368
Email: rockymount@henritzedental.com Website: www.henritzedental.com

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Child ☐ Other_____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ (Mobile): _____

Social Security #: _____ Birth Date: _____

Email Address: _____

Person to notify in case of emergency: _____Phone:_____

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Health Information

WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No
If YES, when is your Due Date?_____

Have you ever HAD or DO HAVE any of the following? Please check those that apply:

☐ AIDS/HIV positive
☐ Allergies to medicines
☐ Anemia
☐ Arthritis
☐ Artificial Joints
Type:_____
☐ Artificial Heart Valves
☐ Arrhythmia
☐ Asthma
☐ Blood Disease
☐ Cancer
Type:_____
☐ Depression
☐ Diabetes
Type:_____
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Fibromyalgia
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head/Neck Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
Type_____
☐ High Blood Pressure
☐ High Cholesterol
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Lung Disease
☐ Mental Illness
☐ Nervous Illness
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pacemaker
☐ Psychiatric Treatment
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sexually Transmitted Disease_____
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid
☐ Tuberculosis
☐ Tumors
☐ Ulcers

OTHER:
☐ _____
☐ _____
☐ _____
☐ _____
☐ I have no medical problems
☐ I am taking no medications

- Have you ever taken bisphosphonate medication (i.e. Fosamax, Actonel, Boniva, Aredia, Zometa, etc…)? ☐ Yes ☐ No
- Have you ever been told you needed to be premedicated for dental work? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Pharmacy (Name, Address, Phone#): _____
- Are you currently taking any medications (Over-The Counter or Prescriptions)? ☐ Yes ☐ No
  If YES, please list on MEDICATION LIST form (next page).
- Please List Medications you have ALLERGIES or ADVERSE REACTIONS to:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____

MEDICATION LIST

NAME: _____
DOB: _____
DATE (as of): _____

DRUG	DOSAGE(mg)	FREQUENCY	PURPOSE/TREATING WHAT?

- Are you under the care of a Primary Care physician? ☐ Yes ☐ No
  If yes, Physician (Name, Address, Phone#): _____
  _____
- Do you have any Health conditions, Surgeries, diseases, etc., not listed that we should be aware of? ☐ Yes ☐ No
  If yes, please explain: _____
  _____

Dental Information

Reason for this visit: _____
Date of Last Dental Checkup: _____
Previous Dentist (Name, Address, Phone#): _____
_____

Please mark any of the following if the answer is YES:

- ☐ Do you wake up in the morning with headaches?
- ☐ Does your jaw make clicking/popping sounds when opening/closing?
- ☐ Difficulty opening or closing your mouth?
- ☐ Clenching or grinding your teeth?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do your gums bleed when you brush or floss?
- ☐ Do you have any swelling or bumps in the mouth?
- ☐ Frequent mouth sores on the lips or in the mouth?
- ☐ Do you have persistent swollen glands?
- ☐ Burning tongue or lips?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening/being lost?
- ☐ Do you currently have any Dental Implants, Dentures or Partials?
- ☐ Have you had Orthodontic treatment (Braces)?

Have you ever been told you have Periodontal Disease (gum disease, or pyorrhea)? ☐ Yes ☐ No
If Yes, Date of last Periodontal Treatment: _____

How often do you brush per day? ☐ 1x ☐ 2x ☐ more than 2x
How often do you floss per day? ☐ 1x ☐ 2x ☐ more than 2x ☐ Never ☐ Occasionally

What type of toothbrush do you currently use? ☐ Manual ☐ Electric
If Manual, ☐ Soft ☐ Medium ☐ Hard
If Electric, what brand? _____

Do you use any of the following mouth rinses? ☐ ACT or Fluoride Rinse ☐ Listerine ☐ Other_____
If so, how often and how much? _____
Do you drink sodas or sweet tea? ☐ Yes ☐ No
If Yes, how often and how much? _____

Do you use tobacco (cigars, cigarettes, smokeless, snuff, or chew)?
If Yes, how long and how often (per day)? _____

If you could change anything about your mouth, teeth or smile, what would it be?
_____
_____
__

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I understand that providing incorrect and/or inaccurate 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, condition or medications taking. I also understand that this information will be held in the strictest confidence.
I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate, and treatment with my informed consent.

_____ Relationship to patient: _____Date:_____
Signature of patient, parent or guardian completing this form

Responsible Party Information (if other than patient)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Dental Insurance Information

Primary

Subscriber's Name: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Referral Information

Whom may we thank for referring you to our practice? _____

Financial Policy

Your payment is due at the time of service!

Patients who carry dental insurance understand that this office will file their insurance as a courtesy. All **estimated** co-payments and deductibles are due at the time of service. **Our office only participates with certain providers but we will file with non-participating insurances as a courtesy**. *Also, the patient understands that he or she is personally responsible for payment for all dental services not covered by their insurance company.*

Patients who have an oral device made for a sleep disorder will pay in full at the time of service(s). Our office will file your medical insurance as a courtesy, except Medicare and Medicaid. **Our office is NOT a participating provider with any medical insurance for these products.**

Patients who do not carry dental insurance understand that payment is due in full at the time of service.

A billing fee will be added to your account if two or more statements need to be sent. If your account becomes delinquent and is sent to a third party collection agency, you are responsible for all costs and fees incurred associated with the collection of any unpaid balances and you will no longer be a part of this practice.

Allowable forms of payment are: Cash, Check, Money Order, Visa, MasterCard, Amex, Discover and Care Credit.

Patients will be charged **$50 for a broken appointment**. To guarantee no charge to your account our office needs to be notified 2 business days prior to the appointment.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any e-mail address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that the Lender may contact me as described above.

If you have any questions, feel free to ask us. We will be glad to help.

I have read the above financial policy and I understand I am responsible for my account.

_____ Date: _____ Relationship to Patient:

_____

Signature of patient, parent or guardian

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Patient Name: _____
Address: _____
Telephone: _____

Section B: To the Patient---Please read the following statements carefully

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 healthcare operations.

Notice of Privacy Practices: 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, and of other important matters about your health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting:
Contact Person: Henritze Dental Group Dr. Steven Anama-HIPAA Administrator
Telephone: 540-776-6555
Address: 4119 Brandon Avenue Roanoke VA 24018

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 Contact 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 treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and your 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 as described in the "Notice of Privacy Practices"

Signature: _____ Date: _____
Personal Representative: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THE CONSENT AFTER YOU SIGN IT