REGISTRATION AND HEALTH HISTORY

Patient Information

First Name ____________________________M.I.______Last Name____

___ Male ___ Female D.O.B. / / SSN____

Street__________________________________#_______ City ______________________State___ Zip Code___________

Cell # ( ) ________________________________Business # ( )______________________________________

E-mail ____How would you like to receive appointment reminders?

(Please check all that apply) ___ Text ___ Email ___ Phone Message

How did you hear about our practice? Check all that apply: __Internet Search __Facebook __Friend __Family

__ Physician Referral _______________________ Employer___________________ Other ____________________

Emergency Contact Name ____ Phone ______________________________

Employer Name ____Address___________________________________

City ____State______________ Zip _____________________________

RESPONSIBLE PARTY

(COMPLETE IF DIFFERENT FROM ABOVE INFORMATION)

Name ___________________________________ Relationship to Patient_________________ Date of Birth___________

Home Address (if different from above) ____

City____State______________ Zip_______________________________

Phone (H):_______________________ (W)_________________________(C)________________________ Prefer ____

E-mail ____Social Security Number ________________________________

DENTAL INSURANCE INFORMATION

Subscriber's Name ____Employer _________________________________

Insurance Company _______________________________________ Phone__________________ Effective Date_______

Group Number ____Subscriber ID___________________________

SECONDARY INSURANCE INFORMATION

Subscriber's Name ____ Employer __________________________________

Insurance Company _______________________________________ Phone__________________ Effective Date_______

Group Number ____Subscriber ID___________________________

Your Primary Physician____Phone___________________________

Approximate Date of Last Visit ________ Have you been hospitalized in the last 2 years? ___ Yes ___ No

If yes, for what reason:____

Medications (prescription and over the counter)____

____

Do you or a family member have sleep disruption from snoring or sleep apnea? Y N

Are you pregnant or nursing? ____

Do you have a history of any of the following?

Scarlet Fever	Y N	Liver Disease	Y N	Autoimmune Disease	Y N
Rheumatic Fever	Y N	HIV / AIDS	Y N	Ulcer	Y N
Heart Murmur	Y N	Anemia	Y N	Cancer	Y N
Mitral Valve Prolapse	Y N	Sickle Cell Anemia	Y N	Psychiatric Disorder	Y N
Valve Replacement	Y N	Leukemia	Y N	Seizures / Epilepsy	Y N
Heart Attack	Y N	Bleeding Problems	Y N	Sinus Problems	Y N
Pacemaker	Y N	Blood Transfusion	Y N	Frequent Headaches	Y N
Stroke	Y N	Diabetes	Y N	Lupus	Y N
High Blood Pressure	Y N	STD	Y N	Acid Reflux / GERD	Y N
Low Blood Pressure	Y N	Tuberculosis	Y N	Radiation Therapy	Y N
Joint Replacement	Y N	Emphysema	Y N	Hearing Loss	Y N
Arthritis	Y N	Asthma	Y N	Tobacco Use	Y N
Hepatitis	Y N				

Allergies: Medication Allergies____

Other Allergies ____

Latex Allergy Y N Have you had an unusual reaction to local anesthetic? Y N

Any other information regarding your health history?____

DENTAL HISTORY

Previous Dentist________________________________ Last Appointment ________ Reason_________________________

Address ____ Phone___________________________

Is there anything about the appearance of your teeth that you would like to improve or change? Y N

Have you ever had a bad dental experience? Y N

Reason for visit with us today ____

MEDICAL CONSENT & PAYMENT OF FEES

Deemed Consent (HIV/ Hepatitis): I understand that if a healthcare provider is exposed to my blood or other body fluids in a manner which may transmit disease, I will be tested for infection with Human Immunodeficiency virus or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider, and the Virginia Department of Health will be notified and appropriate counseling provided if the results are positive.

Payment of professional fees: Payment at the time of services is expected. For your convenience, we accept VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. Our office will be happy to submit claims to your insurance company, **Drs. Stenger, Cole, Gupta and Associates** are not participants in any dental insurance plan. I understand that this practice will make every effort to collect from my insurance company. I hereby authorize Drs. Stenger, Cole, Gupta and Associates to release information to insurance carriers concerning my treatment and **I hereby assign to the dentist all payments for dental services rendered to me or my dependents.** By signing this form, I acknowledge and understand that I am responsible for any amounts not covered by insurance for services rendered to me or my dependents. I hereby agree to pay attorney or collection agency fees on any unpaid balances.

Date____________________________ **Signature** ____