Patient Information

Today's Date: __/__/____

Patients Name: _____
First MI Last

Address:

_____

_____ _____ _____
City State Zip

Email: _____
We will not sell or give out your email address.

Phone# (H) (____) -_____

Phone# (C) (____) -_____

Phone# (W) (____) -_____ Ext: ____

Birth Date ____/_____/_____

SS# _____

Title: _____ Preferred Name:_____

Spouse's Name: _____

Employer: _____

Primary Dental Insurance None ☐

Insurance Name: _____

Address: _____

_____
City State Zip

Phone # (____) _____

Group # (Plan, Local, or Policy #) _____

Subscriber's Name _____

Relation: _____ Date of Birth __/__/_____

Subscriber's ID# _____

Subscriber's Employer: _____

THE DENTAL STUDIO of Hampton Roads

Virginia Beach Norfolk

Serving Hampton Roads for more than 30 years

Referred By:_____

Appointment Reminders:

☐ By Phone ☐ By Email ☐ By Text

Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Secondary Dental Insurance

Insurance Name: _____

Address: _____

_____
City State Zip

Phone # (____) _____

Group # (Plan, Local, or Policy #) _____

Subscriber's Name _____

Relation: _____ Date of Birth __/__/_____

Subscriber's ID# _____

Subscriber's Employer: _____

Office use

Medical History:

Medications currently taking: ☐ None ☐ Insulin ☐ Blood Thinners (including aspirin) ☐ Muscle relaxers ☐ Pain Killer

_____

_____

Have you ever taken: Osteoporosis Meds (ex. Aredia/Fosamax) ☐ Yes ☐ No

Surgery and Medical Conditions: ☐ None _____

Have you ever had a Prosthetic repair to your heart ☐ Yes ☐ No

Y N Heart Attack/Stroke	Y N Chemotherapy	Y N Sinus Problems
Y N Heart Surg./Pacemaker	Y N Radiation Therapy	Y N Stomach Ulcers
Y N Heart Murmur	Y N Artificial Joints	Y N Jaw Problems
Y N Artificial Valves	Y N Arthritis/ Rheumatism	Y N Severe Frequent Headaches
Y N Heart Disease	Y N Thyroid Problems	Y N Drug Abuse
Y N Congenital Heart Defect	Y N Kidney Problems	Y N Seizures/ Epilepsy
Y N Chest Pains	Y N Liver Problems	Y N HIV+/AIDS/ARC
Y N High/Low Blood Pressure	Y N Hepatitis	Y N Psychiatric diagnosis
Y N Bleeding Problems	Y N Asthma	Y N Diabetes
Y N Anemia	Y N Emphysema	
Y N Cancer	Y N Tuberculosis	

Allergies: ☐ None ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Seasonal ☐ Food _____

_____

Do you use tobacco ☐ Yes ☐ No Type _____

Dental Information:

Times a day you brush? _____ Floss _____ Mouth wash _____

What type of tooth brush do you use? _____

Last Dental Exam ____/____/____ Last Dental X –rays ____/____/____

Medical Dr. _____ Medical Specialist _____

Phone # _____ Phone # _____

Emergency Contact _____ Phone # _____

For Women:

Are you pregnant? ☐ Yes ☐ No duration_____ nursing ☐ Yes ☐ No

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

Patient Name _____

The Dental Studio of Hampton Roads

Office use

Our team at The Dental Studio of Hampton Roads is committed to providing the best dental care for your particular needs. We are part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition, we are also dedicated to making top-quality care as cost effective as possible. To assist with your health care investment, we provide the following payment options: Cash or Check, Major Credit Cards (MasterCard, Visa, Discover, Amex), or Care Credit.

Payment is due at the time of treatment. To enable you to proceed without delay, our office offers several financial options. We encourage you to select a financial arrangement that best suits your budget.

A Returned Check Fee of $25.00 will be charged for any check returned for insufficient funds

All account balances over 60 will be assessed a handling charge of 1.5% per month (18%APR). All accounts over 90 days will be transferred to a collections agency. At that time, all costs of collection, including attorney and legal fees, will be added to your account balance.

Insurance Policy

Our goal is to maximize your insurance benefits and make any remaining balance easily affordable. Please be prepared to show your insurance card and driver's license at the time of your visit. If the patient has any insurance changes, it is the patient's/guarantor's responsibility to provide the new information. If this information is not provided at the time of service, the patient/guarantor will be responsible for all charges incurred.

I understand my dental insurance is a contract between the insurance carrier and myself; not between The Dental Studio of Hampton Roads and the insurance carrier. As a courtesy, The Dental Studio of Hampton Roads will gladly submit your insurance to your primary and/or secondary insurance. The patent/guarantor is responsible for their estimated portion and additional fees at the time of service. Please beware that some insurance companies may not cover all services performed in our offices. If for some unforeseen reason your insurance payment is not paid within 60 days, the patient/guarantor is responsible for the charges that are denied or unpaid by insurance.

Authority of Treatment

I hereby grant authority to The Dental Studio of Hampton Roads to administer any treatment, to administer such anesthetics, and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my case.

In the event the doctor of a team member is punctured by a sharp instrument, I agree to have my blood tested. I acknowledge that I have been informed of the risk and possible consequences of the treatment proposed and do authorize the above name doctor(s) to proceed.

Cancellation Policy

If you are unable to keep an appointment, we ask that you kindly provide us with minimum of one business day notice. Our office does not accept cancellation or changes in appointment after hours by voicemail or email: you must call during business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist.

Office Hours at Princess Anne Location

Mon 8-2, Tues 8-6, Wed 8-5, Thurs 8-7, Fri 8-3

Missed Appointment Fee:

Missed appointment fee of $25.00 will be charged to any patient who does not notify our office within 24 hours to cancel or reschedule their appointment.

HIPPA Privacy Practices

We practice standard HIPPA policies and provide a pamphlet to you of our office policies to protect the patient and sensitive information.

********NOTE: Most insurance companies will not pay for composites (white fillings) on posterior teeth. Instead, they pay their allowance for an amalgam (silver filling). You are responsible for the difference. Please keep this in mind; here at Partners in Dental Health LLC, we do not do amalgam fillings. *********

I have read and agree to the policies

_____

Patient's Name (print)

_____ _____

Patient or Parent Signature Date