F. LEE ANGUS JR. DDS

MIDLOTHIAN VIRGINIA

A Division of Central Virginia Dental Care, PLC

Patient Information (Confidential)

Date: _____ Referred By: _____

Patient Name: _____
Last First Middle Nickname

Birth Date: _____ Social Security#: _____ Gender (M/F): _____

Marital Status (check): Minor ____ Single ____ Married ____ Divorced ____ Widow / Widower ____ Other ____

Home Address: _____
Street

_____
City State Zip

Email Address: _____

Phone #s: Home _____ Cell _____ Other _____

Employer: Name _____ Phone _____ Ext. _____

Address _____
Street

_____
City State Zip

Emergency Contact: Name _____ Phone _____

Pharmacy: Name _____ Phone _____

Address _____

Spouse or Responsible Party Information

Name: _____
Last First Middle

Birth Date: _____ Social Security#: _____ Gender (M/F): _____

Home Address: _____
Street

_____
City State Zip

Phone #s: Home _____ Cell _____ Other _____

Employer: Name _____ Phone _____ Ext. _____

Address _____

_____
City State Zip

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Patient Medical History

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain: _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Do you need to pre-medicate due to heart condition or joint replacement?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐

7. Are you allergic to or have you had any reactions to the following?

	Yes	No		Yes	No		Yes	No
Barbiturates	☐	☐	Local Anesthetics (eg. Novacaine)	☐	☐	Latex Rubber	☐	☐
Iodine	☐	☐	Penicillin or any other antibiotics	☐	☐	Sulfa Drugs	☐	☐
Sedatives	☐	☐	Any Metals (e.g. nickel, mercury, etc.)	☐	☐	Aspirin	☐	☐
Other (please list)	☐	☐	_____					

8. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Aids/HIV Infection	☐	☐	Fibromyalgia	☐	☐	Migranes	☐	☐
Anemia	☐	☐	Frequently tired	☐	☐	Mitral Valve Prolapse	☐	☐
Angina	☐	☐	Glaucoma	☐	☐	Parkinson's	☐	☐
Arthritis	☐	☐	Hay Fever/Allergies	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Heart Attack	☐	☐	Recent Weight Loss	☐	☐
Autism	☐	☐	Heart Disease	☐	☐	Respiratory Problems	☐	☐
Blood Thinner	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Heart Trouble	☐	☐	Seizures	☐	☐
Cardiac Pacemaker	☐	☐	Hepatitis/Jaundice	☐	☐	Sexually Transmitted Diseases	☐	☐
Chest Pains	☐	☐	Hearing Impaired/Loss	☐	☐	Sleep Apnea	☐	☐
Cholesterol Problems	☐	☐	High Blood Pressure	☐	☐	Stomach Troubles/Ulcers	☐	☐
Diabetes	☐	☐	Implant	☐	☐	Stroke	☐	☐
Dementia/Alzheimer's	☐	☐	Joint Replacement	☐	☐	Swollen Ankles	☐	☐
Easily Winded	☐	☐	Kidney Disease	☐	☐	Thyroid Problem	☐	☐
Emphysema	☐	☐	Leukemia	☐	☐	Tuberculosis	☐	☐
Epilepsy/Convulsions	☐	☐	Liver Disease	☐	☐	Other _____	☐	☐
Fainting	☐	☐	Low Blood Pressure	☐	☐			

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you bite your lips or cheeks frequently?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you ever had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced clicking, pain, and/or difficulty in opening and/or closing in relation to your jaw?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you feel pain to any of your teeth?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you have (please check) ☐ dentures, ☐ partials and/or ☐ implants?		
15. Have you had oral hygiene instructions?	☐	☐
16. Have you had any periodontal treatment?	☐	☐
17. Do you have Sleep Apnea or do you snore?	☐	☐

In Office Use Only: Reviewed by Dr. Date

PATIENT NAME: _____

Insurance Information

Primary

Name of Insured: _____ Employer: _____

Relationship to Patient: _____ Social Security#: _____ Insured's DOB: _____

Insurance Company (Name & Address): _____

Insurance Phone: _____ Fax: _____

Insurance Group#: _____ Policy ID/#: _____ Effective Date: _____

Cancellation Policy

We ask for **48 hours** advanced notice for cancelling or rescheduling an appointment; otherwise, a **$50 fee** may be assessed to your account. **Note: All cancellation fees must be paid prior to scheduling another appointment.**
The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people – the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.

Signature: _____ Date: _____

Acknowledgement & Release

Insurance: We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, however, the dentist's treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company. We confirm insurance eligibility or predetermine recommended treatment as a courtesy.

Collections: In the event the balance becomes more that 60 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed to Central Virginia Dental Care, PLC (DBA: F. Lee Angus, Jr. DDS). Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

Signature: _____ Date: _____

CONSENT:

1. I hereby authorize Dr. Angus and/or staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis.
2. I authorize the doctor to perform all recommended treatment mutually agreed upon. I also agree to the use of appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine. As stated in the "Payment Policy" form, payment is due and payable at the time services are rendered unless other arrangements have been made. (See form for additional information).
4. I understand that a $50 fee will be assessed for any missed appointments. Should I need to cancel or change any appointments, I understand that I need to give the office 48 hours notice.
5. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

Patient: _____ Date: _____ Witness: _____

Parent or Responsible Party: _____ Relationship to Patient: _____

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Release of Information Consent Form – HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM
You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____
The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ Any of the Above

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____ _____

_____
Signature of Privacy Officer

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