



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 _____

Physician: Name _____ Phone _____

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

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..... | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (eg. Novacaine)..... | <input type="checkbox"/> | <input type="checkbox"/> | Latex Rubber..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (e.g. nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list).... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | |
8. Women Only:
- 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	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Migranes	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Frequently tired	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinner	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Dementia/Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Implant	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			

Patient Dental History

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

In Office Use Only: Reviewed by Dr. _____

Date _____

PATIENT NAME: _____

Dental 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 than 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: _____

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 ARE ACTIVELY INVOLVED IN YOUR HEALTHCARE AND 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:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

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

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> 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:

- | | |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email | |

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