WELCOME TO

PANTOPS PROSTHODONTICS

*Thank you for selecting our dental healthcare team! To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please call us at **434-977-9836** or contact us via email at **frontdesk@pantops.org***

(Please Bring Any X-Rays You Have to Your Initial Exam)

Patient Information *(Confidential)*

Referred by: _____

Name: _____ Birthdate: ____/____/____

Address: _____ SSN: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Circle One: Married Single Divorced Widowed

Cell: (_____) _____ - _____ Email: _____

Occupation: _____ Work Phone: (_____) _____ - _____ ext: _____

Emergency Contact Information: Name: _____

Daytime Telephone Number: _____ (_____) _____ Relationship to you: _____

Dental Insurance Information *(Please Bring Your Dental Insurance Card to Your Initial Exam)*

Name of Insured: _____ Birth Date: ____/____/____ SSN: _____

Relationship to Patient: _____ Employer: _____

Insurance Company: _____ Group #: _____

Phone: (_____) _____ - _____ Policy ID: _____

Address: _____

City: _____ State: _____ Zip: _____

Our policy: Payment is due at each appointment. We are happy to submit your claim to the insurance company. Any benefits will be sent to you directly. If you have any questions, feel free to contact us. Thank you!

Patient Medical History Check the Box if the following applies to you:

★DO YOU NEED TO PREMEDICATE BEFORE APPOINTMENTS?? ☐ YES ☐ NO★

- ☐ Are you under medical treatment now?
- ☐ Have you been hospitalized in the past 5 years for any operation or serious illness?
  If yes, explain: _____
- ☐ Are you taking any medications (including non-prescription medicines)?
  If yes, what medications: _____
  _____
  (Bring a List of Your Medications to Your Initial Exam)

Have you ever used/taken:

- ☐ Fen-Phen/Redux?
- ☐ Fosamax, Boniva, Actonel or any cancer meds containing bisphosphonates? When? _____
- ☐ Viagra, Revatio, Cialis or Levitra in the past 24 hours?
- ☐ Tobacco? Do you smoke cigarettes or a pipe now? Yes or No
- ☐ Do you wearing contact lenses?
- ☐ Do you have a persistent cough or throat clearing not associated with a known illness?

Are you allergic to:

- ☐ Local Anesthetics (like Novocain)?
- ☐ Penicillin or any other antibiotics? Please list _____
- ☐ Barbiturates?
- ☐ Sedatives?
- ☐ Iodine?
- ☐ Aspirin?
- ☐ Metals (like nickel, mercury, etc.)?
- ☐ Latex Rubber?

Name of General Dentist	Name of Primary Care Physician (MD)
Location:	Location:
Phone Number: (_____) _____ - _____	Phone Number:
Date of Last Exam: ____/____/____	Date of Last Exam: ____/____/____

Women: Circle one if you are Pregnant / Nursing
Taking oral contraceptives.

Music Preference: _____

Do you have or have you had any of the following? (*Circle All That Apply*)

High Blood Pressure	Heart Disease	Chest Pains
Heart Attack	Cardiac Pacemaker	Easily Winded
Rheumatic Fever	Heart Murmur	Stroke
Swollen Ankles	Angina	Hay Fever / Allergies
Fainting / Seizures	Frequently Tired	Tuberculosis
Asthma	Anemia	Radiation Therapy
Low Blood Pressure	Emphysema	Glaucoma
Epilepsy / Convulsions	Cancer	Recent Weight Loss
Leukemia	Arthritis	Liver Disease
Diabetes	Joint Replacement	Heart Trouble
Kidney Disease	Hepatitis A, B, C (specify)	Respiratory Troubles
AIDS or HIV Infections	STD	Mitral Valve Prolapse
Thyroid Condition	Stomach Ulcers	Sleep Apnea
		Other_____

Patient Dental History (**check the box if it applies to you**)

- ☐ Do you like your smile? Yes or No
- ☐ Do you feel pain on any of your teeth?
- ☐ Do your gums bleed while brushing or flossing?
- ☐ Are your teeth sensitive to hot/cold liquids or foods?
- ☐ Are your teeth sensitive to sweet/sour liquids or foods?
- ☐ Do you have any sores or lumps in or near your mouth?
- ☐ Have you had any orthodontic (braces) treatment?
- ☐ Do you wear dentures or partials plates?
  Date of placement: ____/____/____
- ☐ Have you received oral hygiene instructions?
- ☐ Have you had any neck, head or jaw injuries?
- ☐ Do you have frequent headaches?
- ☐ Do you clench or grind your teeth?
- ☐ Do you bite your lips or cheeks frequently?
- ☐ Have you had difficult extractions in the past?
- ☐ Have you had prolonged bleeding after extractions

Have you experienced any of the following problems in your jaw: (**check the box if it applies to you**)

- ☐ Clicking? (__Right Side __Left Side)
- ☐ Pain (__joint,___ ears,___ side of face)?
- ☐ Difficulty opening or closing?
- ☐ Difficulty in chewing?

Please Check Any That May Apply:

- ☐ I live alone
- ☐ Feelings of sadness and/or irritability
- ☐ Changes in weight or appetite
- ☐ Changes in sleeping pattern
- ☐ Inability to concentrate, remember or make decisions
- ☐ Fatigue or loss of energy
- ☐ Restlessness or decreased activity noticed by others
- ☐ Worry excessively about many things
- ☐ Experience shortness of breath, palpitations or shaking while at rest
- ☐ Afraid that you will be in a place/situation from which you will not be able to escape
- ☐ Feel compelled to perform certain behaviors repeatedly (turning off lights, checking locks…)
- ☐ Do you use tobacco?
- ☐ How many alcoholic beverages per day do you consume on average? _____
- ☐ Do you use recreational drugs? _____
- ☐ Please describe any current stress: _____

What is your main dental concern? _____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____**Date: ____/____/____**

Signature of Patient (or parent/guardian if minor) **Dentist signature** _____

Pantops Prosthodontics

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434-977-9836 • frontdesk@pantops.org

Financial Responsibility Agreement and Authorization for Treatment

1. I authorize treatment and agree to pay all fees and charges for such treatment promptly upon presentation of my bill. I hereby authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims thereon. I acknowledge that I understand that the above named office is a "Fee for Service" office and that the above named office does not participate with any insurance coverage plan for payment and expect payment the day services are rendered.

2. I understand that this office will file my insurance claim for me as a professional courtesy. I understand that this office bears no responsibility for the collection of any proceeds from my insurance. I understand that it is my responsibility to follow up with the insurance company to ensure payment has been made accordingly.

3. If my account becomes delinquent and is assigned to a collection agency, I agree to pay all costs of collection, including an agency fee, court costs, and attorney's fees. I understand that all accounts with a balance over 60 days will be assessed a late charge per month on the unpaid balance (unless prior financial arrangements have been made). I also hereby waive the benefit of my homestead exemption as to this debt.

4. I understand that the office reserves the doctors' time for only one patient at a time. I will make every effort to honor my reservation with the doctor and understand that excessive broken appointments or cancellations could result in a missed appointment fee as well as discontinuation of treatment. I also understand that the office does not make confirmation or reminder calls for appointments unless otherwise requested by me.

5. I acknowledge that I have received or been offered a copy of Pantops Prosthodontics Notice of Privacy Practices. (Available at the front desk at check-in or any time).

6. All treatment plans and costs are considered estimates and will be honored for three months after presentation at the discretion of the doctor if treatment is not immediately initiated. All payment plans, interest rates and payment agreements may also be adjusted after three months if treatment is not pursued. All payment agreements may be null and void if the agreed terms are violated.

7. I understand that my exam visit **may** be recorded on audio-tape for clarification purposes.

8. Photographs are an important part of our clinical record. While they are usually contained only to your personal record, occasionally we choose photographs to use for continuing education purposes or as examples of the quality of our work to other patients. They may also be used in communication with other health care professionals, educational publications (dental journals), & for advertising purposes including website publications. If the photographs and/or videos are used, my name or other identifying information will be kept confidential. No compensation, finanacial or otherwise, is expected for use of these photographs. (Check a box)

   - ☐ **I do not mind if my photographs are used in any of the above stated situations.**
   - ☐ **I do not mind if my teeth are shown as long as they are without identifying features.**

_____ ____/____/____

[Patient/Guardian Signature] [Date]

_____

[Patient/Guardian Printed Name]