Welcome to Lynchburg Family Dentistry!

Name: _____
Last First M.I. Preferred

Birthdate: _____ Social Security Number: _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Home Phone: _____ Work Phone: _____ Cellular Phone: _____
(include extension, if any)

OK to Text? ☐ Y ☐ N

Email: _____

Contact preference (may check more than one):

Home Phone: ☐ Cellular Phone: ☐ Work Phone: ☐ Email: ☐

(If selecting "email," note that we will contact you via phone if contact is not returned in time for a particular question or issue)

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Phone: _____

Subscriber Name: _____ Subscriber Date of Birth: _____ Subscriber ID: _____

Your relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Employer: _____ Group Name: _____ Group #: _____

If you may have secondary dental insurance, please let us know.

Do you have a panoramic x-ray or full mouth x-rays that are less than 5 years old? ☐ Y ☐ N

Do you have bitewing x-rays that are less than 1 year old? ☐ Y ☐ N

If yes to either of the above two questions, please complete our record release form.

Name of former dentist: _____ City/State: _____

Date of last cleaning/exam: _____

Medical History

Last Name:_____ First Name:_____ Birthdate:_____ M/F: ____

Name of Medical Doctor:_____ City/State:_____

Emergency Contact:_____ Phone:_____ Relationship: _____

Mark any medications that you are no longer taking and add any new ones:

☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____

Are you allergic to any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Latex	☐	☐	Penicillin	☐	☐	Aspirin	☐	☐	Codeine
☐	☐	Metal	☐	☐	Local Anesthetics	☐	☐	Acrylic	☐	☐	Sulfa

Other:_____

Do you use controlled substances?:_____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?:_____

Do you take, or have you taken, Phen-Fen or Redux?:_____

Do you have any of the following medical conditions? (mark yes or no for all)

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV Positive	☐	☐	Diabetes	☐	☐	Hepatitis B or C	☐	☐	Recent Weight Loss
☐	☐	Alzheimer's Disease	☐	☐	Drug Addiction	☐	☐	High Blood Pressure	☐	☐	Renal Dialysis
☐	☐	Anaphylaxis	☐	☐	Easily Winded	☐	☐	High Cholesterol	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Emphysema	☐	☐	Hives or Rash	☐	☐	Rheumatism
☐	☐	Angina/Chest Pains	☐	☐	Epilepsy or Seizures	☐	☐	Hypoglycemia	☐	☐	Scarlet Fever
☐	☐	Arthritis/Gout	☐	☐	Excessive Bleeding	☐	☐	Irregular Heartbeat	☐	☐	Shingles
☐	☐	Artificial Heart Valve	☐	☐	Excessive Thirst	☐	☐	Joint Replacement	☐	☐	Sickle Cell Disease
☐	☐	Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Kidney Problems	☐	☐	Sinus Trouble
☐	☐	Blood Disease	☐	☐	Frequent Cough	☐	☐	Leukemia	☐	☐	Spina Bifida
☐	☐	Blood Transfusion	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stomach/Intestinal Disease
☐	☐	Breathing Problem	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Stroke
☐	☐	Bruise Easily	☐	☐	Hay Fever	☐	☐	Lung Disease	☐	☐	Swelling of Limbs
☐	☐	Cancer	☐	☐	Heart Attack/Failure	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Disease
☐	☐	Chemotherapy	☐	☐	Heart Murmur	☐	☐	Osteoporosis	☐	☐	Tonsillitis
☐	☐	Cold Sores/Fever Blisters	☐	☐	Heart Pacemaker	☐	☐	Pain in Jaw Joints	☐	☐	Tuberculosis
☐	☐	Congenital Heart Disorder	☐	☐	Heart Trouble/Disease	☐	☐	Parathyroid Disease	☐	☐	Tumors or Growths
☐	☐	Convulsions	☐	☐	Hemophilia	☐	☐	Psychiatric Care	☐	☐	Ulcers
☐	☐	Cortisone Medicine	☐	☐	Hepatitis A	☐	☐	Radiation Treatments	☐	☐	Venereal Disease
									☐	☐	Yellow Jaundice

Other:_____

_____

Women, are you:

Pregnant?: Y ☐ N ☐ Trying to get pregnant?: Y ☐ N ☐ Nursing?: Y ☐ N ☐

Due Date:_____ Name of oral contraceptive, if applicable:_____

General:

Have you ever been hospitalized or had a major operation?:_____

Ever had a serious head or neck injury?:_____

Are you on a special diet?:_____

Tobacco use? If so, what kind and how much?:_____

Unusual reaction to dental injections?:_____

Reason for today's visit:_____ Are you in pain?:_____

Date: Signature:_____

(Patient or Parent/Guardian if patient is minor)

THOMAS C. DRAPER, DMD

OFFICE AND AUTHORIZATION POLICIES: PLEASE READ THIS CAREFULLY

We welcome any questions regarding office policies, insurance and of course, fees.

We enforce a 24-hour cancellation notice and rescheduling policy. In accordance with this policy, if an individual calls to cancel/ reschedules within 24 hours of their appointment or does not show up for their scheduled time, the appointment is considered broken. In this case, we are authorized to charge a missed appointment fee of $40. If the patient is late by 15 minutes or more to their appointment, we will break the appointment as a no call, no show and the appointment will need to be rescheduled. If interrupted appointments continue, the patient must pay the $40 fee before scheduling future appointments. Upon arrival, the rate is credited to the cost of the scheduled visit. However, if this appointment is also missed, the deposit is non-refundable.

Insurance can be a hassle, and we want your experience to be as stress- free as possible. We fill out your claim forms and bill out your procedures to your insurance company for you. It is important before carrying out any treatment that we give you our recommendation of treatment and estimating cost of that treatment. Any questions you have regarding insurance will be answered to the best of our abilities, we can also send out a pre-determination for you to determine a rough estimate of what insurance plans to pay. Please note that these determinations are subject to change at any time.

When payment is received from your insurance company and applied to your account, any balance due will be billed to you and any overpayment will be refunded or credited to your account.

We accept cash, checks and credit cards for the payment of dental services.

I certify that I have read and understand the above information to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits that would otherwise be paid to me. I agree to be responsible for the payment of all services rendered on my behalf or on behalf of my dependents. I understand and accept the 24 hour cancellation policy and it will apply to my dependents and myself, unless the office waives otherwise.

Signature of Patient:_____ Date:_____

(Parent/Guardian, please sign for your minor)

Lynchburg Family Dentistry
Thomas C. Draper, DMD
22437 Timberlake Rd
Lynchburg, VA 24502

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:_____

Patient Address:_____

Patient Phone Number:_____

I authorize this practice my consent to use or disclose my protected health information under the following terms and conditions:

1) The information may be released to carry out my treatment, to obtain payment from insurance companies, and to coordinate with other dental and medical professionals regarding my treatment.

2) The information may be released to the following family members (please list):

_____

3) A copy of the Notice of Privacy Practices was available for a more complete description of uses and disclosures of my information prior to my signing this consent form.
I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request if I do not sign this form. I know that sometimes state or federal laws change this possibility.

4) I understand that I may revoke this consent at any time by making a request in writing that excludes my consent on information already used or disclosed. I may send or hand this note to the receptionist or other staff at Lynchburg Family Dentistry.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PERSONALLY-IDENTIFYING, PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature:_____ Date:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Print Name:_____

Relationship to Patient:_____