New Patient Information Form

Full name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: ☐☐☐-☐☐-☐☐☐☐ Date of Birth: ☐☐/☐☐/☐☐☐☐

Home Phone: ☐☐☐-☐☐☐-☐☐☐☐ Work #: ☐☐☐-☐☐☐-☐☐☐☐

Cell Phone: ☐☐☐-☐☐☐-☐☐☐☐ Email: _____

Check one: Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

If student, name of school/college: _____ City: _____ State: _____

If minor, Parent or Guardian's name: _____ Occupation: _____

Your employer, or parent's employer: _____ City: _____ State: _____

Spouse's name: _____ Spouse's employer: _____

Work #: ☐☐☐-☐☐☐-☐☐☐☐ Cell Phone: ☐☐☐-☐☐☐-☐☐☐☐

Person to contact in case of an emergency: _____ Relationship: _____

Contact's phone: ☐☐☐-☐☐☐-☐☐☐☐ Cell Phone: ☐☐☐-☐☐☐-☐☐☐☐

Whom may we thank for referring you? _____

What source of information did you use to learn about and contact our office? (check all that apply)

I was referred ☐ Yellow Pages ☐ Radio ☐ Local paper ☐ Internet Search ☐ Our Website ☐

Please describe in more detail: _____

(Who referred you? Which yellow pages? Which Radio Station? What search engine did you use?)

Dental and Medical History

Please place an answer next to each item. If the item does not apply to you, put N/A in the space provided. Health conditions can play an important role in your oral health care. Please answer all questions as completely as possible.

Your Name: _____ Date: _____

Your physician's name: _____ Do you receive an annual physical? Yes ☐ No ☐

Have you had any serious illness or surgery in the last 2 years? ☐ Yes ☐ No If yes, please provide details below.

Do you have any allergies to medications or products? ☐ Yes ☐ No If yes, please provide details below.

Indicate allergies here:

Are you allergic to latex? ☐ Yes ☐ No Do you use a hearing aid? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No ☐ I quit _____ months/years ago. If yes, which type? _____

Are you pregnant or nursing? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No

For Parents of Minor Patients

Does your child have learning or behavioral difficulties? ☐ Yes ☐ No If yes, please explain below.

Please check the box next to any heath conditions that apply to you and provide as much detail as possible in the box provided at the bottom of the list.

- ☐ Blood / bleeding conditions
- ☐ Cancer
- ☐ Diabetes
- ☐ Cardiac (heart) conditions
- ☐ Digestive or G.I conditions
- ☐ Kidney conditions
- ☐ Other condition not listed
- ☐ Breathing or lung conditions
- ☐ Liver conditions
- ☐ Stroke
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ Mitral Valve Prolapse
- ☐ Digestive or G.I conditions
- ☐ Rheumatic heart disease
- ☐ Heart murmur
- ☐ Artificial joint or heart valve
- ☐ Cardiac Pacemaker
- ☐ Hepatitis
- ☐ HIV / AIDS

Provide details for the box or boxes you checked above.

Dental Care History

Do you have any history of TMJ, jaw pain, surgery or injury? ☐ Yes ☐ No If yes, please explain in the box below.

Do you have any history of oral tumors, growths or lesions? ☐ Yes ☐ No If yes, please explain in the box below.

Do you have any other oral conditions or concerns? ☐ Yes ☐ No If yes, please explain in the box below.

Provide details for the box or boxes you checked above.

Medication Information

Please list all medications, including non-prescription medications, that you are currently taking and the medical condition for which you are taking them. Some dental treatment may require you to take medication. This information is important in order for us to prescribe the best medication for your dental treatment that will work properly and not cause an issue with any other medication you may be taking.

Drug Name	Dosage	Condition you are treating with this medication.

Additional Medical Information

If there is any other medical information that you have not indicated on this form, please use the space below to do so. For example, if you are seeing a specialist for treatment of a particular condition, please provide the specialist's information and the condition he or she is treating for you in the box below.

I certify that the information I have provided on this form is complete and accurate to the best of my ability and knowledge. I agree to notify Village Dental immediately if I learn at any time that any of the information I have provided is inaccurate or changes, and understand that it is my sole responsibility to notify Village Dental of new information prior to receiving care.

Printed Name: Signature: Date:

HIPAA Patient Consent Form

By signing this form, you consent to the use and disclosure of your protected health information by Village Dental and Jeffrey A. Spence, DDS, PC, their staff and business associates for treatment and healthcare operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices, ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by contacting the office of Village Dental at (434) 589-6999 and requesting a copy. Any revised Notice is also posted in the office of Village Dental.

You have the right to request that we restrict our use or disclosure of your protected health information that we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to these restrictions. However, if we do agree to restrictions, they would then be binding upon us at the time of agreement. You may refuse to consent to the use or disclosure of your protected health information. If you choose to refuse to this consent, you must make this refusal to us in writing. Under the law, we have the right to refuse to provide treatment or care to you if you choose to refuse to disclose your protected health information (PHI).

This form is also used to obtain acknowledgement of receipt of OUR NOTICE of privacy practices.

I have reviewed, understand and agree to the content of the notice of privacy and place no restrictions upon Village Dental , Jeffrey A. Spence, DDS, PC, their staff and or business associates for the use and disclosure of my protected health information.

Printed Patient Name: _____ Date: _____

Relationship to Patient: _____ Signature: _____

In the course of providing healthcare, it is often necessary to communicate with a patient's spouse regarding treatment and payment information. Please sign in the space below to permit Village Dental, Jeffrey A. Spence, DDS, PC, their staff and business associates to freely communicate with your spouse regarding your care and payment information.

Signature: Date:

Note: Village Dental sends courtesy appointment reminders by US mail and may do so by email to the email address you provide for this purpose. Please sign below to allow Village Dental to send you this information.

Signature: _____ Date: _____

Your email address: _____