

New River Periodontics & Dental Implant Center, PC

John Buyer, DDS, MPH, MS, MSS

John Lentz, DDS

2612 Sheffield Drive
Blacksburg, VA 24060

5002-B Brambleton Avenue
Roanoke, VA 24018

PATIENT INFORMATION

Name FIRST _____ MI _____ LAST _____ Title _____ Date of Birth _____

*SS# _____ Height _____ Weight _____

Street Address _____

Mailing Address _____

City _____ State _____ Zip Code _____

Email _____

Home Phone () _____ - _____ Cell () _____ - _____ Work () _____ - _____

Employer _____ Occupation _____

Who is your General Dentist? _____

❖ DO YOU HAVE DENTAL INSURANCE? Yes / No

Please note that we only participate with Delta Dental and ONLY file dental insurance.

We DO NOT file medical insurance or Medicare for dental procedures. Initial: _____

***IF YOU CHOOSE NOT TO GIVE YOUR SOCIAL SECURITY NUMBER,** then we will collect full payment at the time of your appointment. Reimbursed insurance benefits will be credited to your account and/or returned to you in like manner. **All Co-Pays and Co-Insurance amounts are to be paid at the time of service.** Once payment is received from your insurance company, we will send you a statement detailing any refund, balance owed, or applied to future treatment cost.

PRIMARY DENTAL INSURANCE CARRIER _____ ID _____

Group # _____ Insurance Co. Address _____

INSURANCE Subscriber's Name _____ Date of Birth _____

Relationship to Patient _____ *Subscriber SS # _____

Subscriber's Employer _____

SECONDARY DENTAL INS. CARRIER _____ ID _____

Group # _____ Insurance Co. Address _____

INSURANCE Subscriber's Name _____ Date of Birth _____

Relationship to Patient _____ *Subscriber SS # _____

Subscriber's Employer _____

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN PATIENT:

Name _____ Social Security # _____

Address _____

Phone _____ Relationship _____

EMERGENCY CONTACT INFO:

Name _____ Relationship _____ Phone _____

Names of Persons I Authorize to Obtain Information Regarding My Treatment, Appointments and Account:

HEALTH INFORMATION

Have you been under a physician's care in the past 5 years? Yes No

* Have you had any changes in your health in the past 5 years?* Yes No

*If Yes, please list reasons: _____

Have you had any serious illness, operation, or hospitalization in the past?* Yes No

Do you get short of breath climbing 1 flight of stairs? Yes No

Do you smoke? If Yes, how many packs per day? _____ Yes No

Do you drink alcoholic beverages? Yes No

Have you ever had excessive bleeding following dental treatment? Yes No

Does your jaw "click or pop" while eating? Yes No

Have you had previous gum treatments? Yes No

* Have you ever been told to take an antibiotic before a dental appointment? Yes No

*If Yes, list reasons: _____

****PLEASE LIST ALL ALLERGIES, if any, and current medications and supplements you are taking on page 3.**

CHECK ALL CONDITIONS THAT APPLY TO YOU:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Hives/Skin Rash	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Joint Replacement Type _____	<input type="checkbox"/> Steroid/Cortisone Use
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Kidney	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Valve Replacement	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Blood Donor Ineligible	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Psychiatric Problems/Care	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Currently Pregnant Due Date _____

Other Conditions _____

ALL KNOWN ALLERGIES	MEDICATIONS YOU ARE TAKING	SUPPLEMENTS YOU ARE TAKING

Assignment of Benefits and Authorization to Release Information

I hereby authorize New River Periodontics & Implant Center, PC to release to any insurance company or other health care benefit programs any information, including medical or dental history, treatment or other services rendered in order that they may process any claim for reimbursement. I further authorize payment directly to New River Periodontics & Implant Center all insurance benefits or reimbursement otherwise payable to me.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. Your benefits are an agreement between you and your employer and not an agreement between the insurance company and New River Periodontics.

I AGREE THAT ALL PAYMENT I OWE IS DUE WHEN SERVICES ARE RENDERED.

IF UNABLE TO KEEP YOUR APPOINTMENT PLEASE GIVE US 48 BUSINESS HOURS NOTICE.

Patient Signature _____ Date _____ Dr. Signature _____

Patient Signature _____ Date _____ Dr. Signature _____

Patient Signature _____ Date _____ Dr. Signature _____

Patient Signature _____ Date _____ Dr. Signature _____

Patient Signature _____ Date _____ Dr. Signature _____

Patient Signature _____ Date _____ Dr. Signature _____

Patient Signature _____ Date _____ Dr. Signature _____