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 file dental insurance. As of 3/14/19 we will no longer be "in network" with DELTA DENTAL, but will continue to process your DELTA DENTAL claim as an "out of network" provider. 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:

☐ Anemia	☐ Epilepsy	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Arthritis	☐ Headaches	☐ Hives/Skin Rash	☐ Sinus Problems
☐ Asthma	☐ Heart Trouble	☐ Joint Replacement Type___________	☐ Steroid/Cortisone Use
☐ Anxiety	☐ Chest Pain	☐ Kidney	☐ Stroke
☐ Cancer	☐ Heart Murmur	☐ Liver Disease	☐ Thyroid_______________
☐ Diabetes	☐ Heart Valve Replacement	☐ Lung Disease	☐ Tuberculosis
☐ Autoimmune Disease	☐ Hepatitis	☐ Osteoporosis	☐ Ulcers
☐ Blood Donor Ineligible	☐ AIDS/HIV	☐ Psychiatric Problems/Care	☐ Venereal Disease
☐ Sleep Apnea	☐ Chemotherapy	☐ Radiation Therapy	☐ 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_______________________