New River Periodontics & Dental Implant Center, PC

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2612 Sheffield Drive
Blacksburg, VA 24060

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PATIENT INFORMATION

Name FIRST_____ MI_____ LAST_____ Title_____ Date of Birth_____

**** **SS #**_____ Height_____ Weight_____

Street Address_____

Mailing Address _____

City_____ State_____ Zip Code_____

Email _____

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

Employer_____Occupation_____

Who is your **General Dentist**? _____

Emergency Contact _____Relationship_____ Phone( )_____ -_____

INSURANCE INFORMATION Please note that all dental insurance claims are filed as "out of network." We do not file medical insurance, Medicare, Medicaid or dental plans associated with Medicare or Medicaid. All Co-Pays and Co-Insurance amounts are collected at the time of service**.** Your benefits are an agreement between you and/or your employer and not an agreement between the insurance company and New River Periodontics.

**** **If you choose not to give your Social Security number, we will collect in full at each appointment**. **** **Initial:** _____

PRIMARY DENTAL INSURANCE _____ ID_____

Group #_____ Insurance Co. Address _____

Subscriber's Name_____ Date of Birth_____

Subscriber's Address _____

Subscriber's Employer_____ Subscriber SS #_____

Relationship to Patient _____

SECONDARY DENTAL INSURANCE_____ID_____

Group #_____ Insurance Co. Address _____

Subscriber's Name_____ Date of Birth_____

Subscriber's Address _____

Subscriber's Employer_____ Subscriber SS #_____

Relationship to Patient _____

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN PATIENT:

Name_____ Social Security # _____

Address _____

Phone _____ Relationship _____

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** the in past 5 years**?** ..... Yes No
PLEASE LIST HEALTH CHANGES:

_____

Have you had any serious illness, operation, or hospitalization in the past?..... Yes No
If "yes", please list here_____
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", please list reasons:** _____

PLEASE CHECK:

___Anemia	___Autoimmune Disorder	___High Blood Pressure	___Steroid, Cortisone Use	___Skin Rash, Hives
___Arthritis	___Blood Donor Ineligible	___Cancer	___Stroke	___Sleep Apnea
___Asthma	___Heart Trouble	___Chemotherapy	___Osteoporosis	___Sinus problems
___Diabetes	___Chest Pain	___Radiation Therapy	___Thyroid	___Pregnant
___Epilepsy	___Heart Murmur	___Liver Disease	___Tuberculosis	Due Date_____
___GERD, Ulcers	___Heart Valve Replacement	___Lung Disease	___Anxiety	
___Headaches	___Rheumatic Fever	___Venereal Disease	___Psychiatric Care	
___Hepatitis	___Kidney Disease	___AIDS, HIV	___Joint Replacement, Date: _____	

OTHER CONDITIONS _____

MEDICATIONS (Please print)	**SUPPLEMENTS**	**ALL KNOWN ALLERGIES**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy:_____Phone: ( )_____-_____

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.

IF UNABLE TO KEEP YOUR APPOINTMENT, PLEASE GIVE 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_____