255 FAIRFAX PIKE, SUITE 4, STEPHENS CITY, VA 22655 | 540-692-9264 | HUTCHENSFAMILYDENTISTRY.COM

HUTCHENS FAMILY DENTISTRY

PATIENT INFORMATION

First Name:_____ MI:_____ Last:_____ Nickname: _____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

DOB: _____ ☐ Male ☐ Female SS#: _____

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

Employer: _____

State ID/Driver's License #:_____ E-mail Address: _____

Name of Physician:_____ Physician Phone: _____

In case of Emergency Contact:_____ Relationship:_____ Phone: _____

How did you hear about our office? _____

PATIENT HEALTH HISTORY

Indicate if you have a history of any of the following conditions.

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS / HIV Positive	☐	☐	Drug Use	☐	☐	Jaundice	☐	☐	Radiation Treatment	☐	☐
Alcoholism	☐	☐	Excessive Bleeding	☐	☐	Joint Replacement	☐	☐	Respiratory Problems	☐	☐
Allergies	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Kidney Dialysis	☐	☐	Rheumatism Scarlet	☐	☐
Arthritis	☐	☐	Hay Fever	☐	☐	Latex Sensitivity	☐	☐	Fever	☐	☐
Asthma	☐	☐	Head Injuries	☐	☐	Lupus	☐	☐	Sinus Problems	☐	☐
Blood Disease	☐	☐	Hearing Impaired	☐	☐	Low Blood Pressure	☐	☐	Stomach Ulcers	☐	☐
Bone Disease	☐	☐	Heart Disease	☐	☐	Malignancies	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Heart Murmur	☐	☐	Neck / Back Problems	☐	☐	Thyroid Disease	☐	☐
Chest Pain	☐	☐	Hepatitis Hepatitis	☐	☐	Nervous Disorders	☐	☐	Tuberculosis	☐	☐
Circulatory Problems	☐	☐	Carrier	☐	☐	Pacemaker	☐	☐	Tumors or Growths	☐	☐
Convulsions/Seizure	☐	☐	High Blood Pressure	☐	☐	Prosthetic Joints	☐	☐	Ulcers	☐	☐
Diabetes	☐	☐	HPV	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐

PATIENT MEDICAL HISTORY

List any medications you're taking, including non-prescription drugs:

_____

_____

_____

Are you allergic to any medications? ☐YES ☐NO (If yes, please list below)

_____

_____

Are you in good health? ☐YES ☐NO

Date of last medical exam: _____

Have you ever been hospitalized? ☐YES ☐NO (If yes, please list below)

_____

_____

Are there any additional medical concerns you think we should know about?

☐YES ☐NO (If yes, please list below)

_____

_____

_____

_____

Do you have a depressed immune system? ☐YES ☐NO

Have you had an allergic reaction to food? ☐YES ☐NO

Do you smoke or chew tobacco? ☐YES ☐NO

Have you had Heart Surgery? ☐YES ☐NO

Are you now under the care of a medical doctor? ☐YES ☐NO

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc) ☐YES ☐NO

FEMALE PATIENT HISTORY

Are you taking birth control / contraception? ☐YES ☐NO

Are you pregnant? ☐YES ☐NO Due Date: _____

Are you nursing? ☐YES ☐NO

Is there a possibility that you're pregnant? ☐YES ☐NO

HUTCHENS FAMILY DENTISTRY

DENTAL HISTORY INFORMATION

Date of last dental visit? _____

Name of your previous dentist: _____

Reason for today's visit? _____

Have you ever had an oral cancer screening? ☐YES ☐NO

How often do you floss your teeth? _____

Do your gums bleed when you brush? ☐YES ☐NO

Have you ever been treated for periodontal disease? ☐YES ☐NO

Have you ever had complications from an extraction? ☐YES ☐NO

Have you ever heard a popping or clicking when you chew? ☐YES ☐NO

Are you prone to frequent headaches? ☐YES ☐NO

Do you grind or clench your teeth? ☐YES ☐NO

Do you have sores or swelling on your gums, lips, or cheeks? ☐YES ☐NO

Have you ever had orthodontic treatment? ☐YES ☐NO

Do you snore? ☐YES ☐NO

Do you have problems with bad breath? ☐YES ☐NO

Have you ever had an allergic reaction to dental work? ☐YES ☐NO

Have you ever used an electric toothbrush? ☐YES ☐NO

Are your teeth sensitive to hot, cold, or pressure? ☐YES ☐NO

On a scale from 1 to 10, with 10 being of the highest importance, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile, which would it be:

- ☐ Whiter Teeth
- ☐ Straighter Teeth / Remove Gaps Between Teeth
- ☐ Repair Chipped Teeth / Replace Missing Teeth
- ☐ Show Less Gums

Date:

Dr. Signature:

PAYMENT AGREEMENT & ACKNOWLEDGEMENTS

I agree that I am responsible for all services rendered and that payment is due and payable to the Practice at the time services are rendered. I agree to pay all deductibles and co-pays at the time of service. I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the practice for what is not paid by my insurance company. I understand that the Practice may charge a late fee if payment on my account is not received by the due date; an amount equal to $35, for each returned check, and 3) a fee for each appointment that is canceled without at least 24 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

RESPONSIBLE PARTY:

Full Name:_____ DOB:_____ SSN#: _____

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

Home Phone:_____ Work phone:_____

Employer Name: _____

Date:

INSURANCE INFORMATION:

Primary Insurance Name:_____ Address:_____ DOB: _____

Name of Insured:_____ Relationship:_____ ID Number:_____ Group Number: _____

Secondary Insurance Name:_____ Address:_____ DOB: _____

Name of Insured:_____ Relationship:_____ ID Number:_____ Group Number: _____

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays as deemed necessary by the dentist.
I acknowledge having received a copy of the Practice's Notice of Privacy Practices and HIPAA. I agree that a photocopy of this authorization is as valid as the original.

Reviewed by:

Patient / Parent / Guardian Signature:_____ **Date:**_____