Welcome!

Name____Birth Date________________ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Divorced ☐ Widowed AGE_____________SSN____________________________________

Address____City/State/Zip_______________________________________

Email____Home Phone______________________Cell__________________

Employer_________________________________Job Title________________________Work Phone__________________

Person Responsible for Account:

Name____________________________________Relationship_________________________Phone___________________

Address____City/State/Zip______________________________________

☐ College Student College Name___________________________________Expected Graduation Date_____________

Emergency Contact________________________________Relationship_________________Phone___________________

*Primary Dental Insurance Company*____________________________________Policy/Group#_______________________

Employee's Name______________________________Birth Date___________________SSN/ID#______________________

*Secondary Dental Insurance Company*____________________________________Policy/Group#_______________________

Employee's Name_________________________________Birth Date________________SSN/ID#______________________

Reason for appointment?____________________________________Referred by?__________________________________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	Heart Problems	☐	☐	Kidney Disease	☐	☐	Use of Bisphosphonates
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Currently Pregnant (# of weeks ______)
☐	☐	Heart Valve Replacement	☐	☐	HIV	☐	☐	Allergic to Penicillin
☐	☐	Liver Disease	☐	☐	Hospitalized within last year	☐	☐	Allergic to other Medications
☐	☐	Hepatitis	☐	☐	Cancer or Chemotherapy	☐	☐	Allergic to Latex
☐	☐	Bleeding Problems	☐	☐	Joint Replacement			

List medication allergies____

Medications currently taking____

Please list any other medical condition we should know ____

Read & Initial all that apply:

_____Please share my existing dental treatment, needs and financial information with my spouse/significant other.

_____My child is a minor and I authorize the minor to seek and consent to treatment without an adult present.

_____I acknowledge the Notice of Privacy Practices Policy. I understand I may receive a copy upon request.

_____I understand I may refuse to sign the Privacy Practices Acknowledgment.

I hereby authorize any payment of dental benefits be made directly to VPDA. I also understand that any amount not covered by insurance is my responsibility and is due at time of treatment. I, the undersigned patient, or legally responsible party authorizes treatment to be rendered, and assume full financial responsibility. I acknowledge that all noncurrent balances and accounts over sixty days shall incur a service charge of 1.5% per month (18% annually) on unpaid balances. The cost incurred in collecting this account including court costs, agency fees and attorney fees shall be added to your balance due.

Method of payment for today: (Please Circle) Check Cash Credit Card

Signature of Person Responsible for Account____Date________________

Revised 3/17/2014