Thoroughgood Dental
1609 Pleasure House Rd
Virginia Beach Va 23455
757-464-3321

Patient Intake Information

SS # ____ ____ _____

Patient Information

Name: _____ Today's Date: _____

DOB: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ □ Home □ Cell Alt Phone: _____

Email: _____ Primary Language: □ English □ Spanish □ Other: _____

Emergency Contact: _____
Name Relationship Phone

What is the reason for your visit / Chief Complaints? _____

_____

How did you hear about us? _____

Primary Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder DOB: _____

Policy Number: _____ Group Number: _____

Patient Relationship to Subscriber: _____

Secondary Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder DOB: _____

Policy Number: _____ Group Number: _____

Patient Relationship to Subscriber: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company and assign directly to Dr. Dental all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named medical facility may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable to related services. This consent will stay in effect as long as I am a patient with the above-named medical facility.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Name of Patient, Parent, Guardian, or Personal Representative (Print)

_____ _____
Date Relationship to Patient

Preferred Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Street Address: _____

Dental History and Oral Health

Date of last dental visit: _____ Date of last dental X-ray: _____

Have you ever been treated for periodontal disease? □ Yes □ No Have you ever had Novocaine / other local anesthetic? □ Yes □ No

One a scale of 1 (not happy) to 10 (very happy), how happy are you with your smile? _____

Please check any dental conditions that apply to you:

□ Pain in Jaw (TMJ) □ Teeth Grinding / Clenching □ Use Tobacco Products □ Swollen / Bleeding Gums

□ Mouth Sores □ Broken / Loose Teeth □ Sensitive Teeth □ Difficulty Chewing / Swallowing

□ Crooked / Spaced Teeth □ Tooth Color / Appearance

Are you in pain? □ Yes □ No Do you experience any fears or anxieties related to dental treatment? □ Yes □ No

If Yes, please explain: _____

Do you need to be pre-medicated before dental treatment? □ Yes □ No

Medical History

Primary Care Provider (Name and Phone): _____

Date of last physical: _____ Are you taking birth control? □ Yes □ No □ Not Applicable

Are you currently pregnant or nursing? □ Yes □ No □ Not Applicable Estimated due date, if applicable: _____

Please list any prior hospitalizations or surgeries, including dates: _____

_____

Is the patient currently using alcohol or drugs (including tobacco)? □ Yes □ No

If yes, Type: _____ Frequency: _____ Amount: _____

Do you require antibiotics prior to dental procedures? □ Yes □ No

Are you currently taking or have you taken any steroid / cortisone therapy in the last 2 years? □ Yes □ No

Are you currently taking or have you ever taken Oral Bisphosphonates (e.g. FOSAMAX, BONIVA) or IV Bisphosphonates? (e.g. ZOMETA, AREDIA)? □ Yes □ No If yes, for how long? _____

Are you allergic or have you ever had an adverse reaction to any of the following?

□ None □ Amoxicillin □ Aspirin □ Codeine □ Epinephrine □ Latex □ Ibuprofen
□ Metals □ Penicillin □ Sulfa □ Tetracycline □ Erythromycin □ Z-pack

Please specify any other known allergies: _____

Have you ever taken any of the group of drugs collectively referred to as “fen-phen”? These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

Please list any current prescribed medications or supplements you are taking, or have used over a long period of time (e.g. prescription, dosage, dates):

Prescription / Supplement Name	Dosage/ Frequency	Dates

Conditions *(Please check all that apply)*

- ☐ None
- ☐ Alcoholism
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
  Type & Age: _____
- ☐ Aspirin Therapy
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Cancer
  Type: _____
- ☐ Chemotherapy
- ☐ Coumadin Therapy
- ☐ Dementia
- ☐ Diabetes
  Type: _____
- ☐ Drug Addiction
- ☐ Epilespy
- ☐ Excessive Bleeding
- ☐ Fainting / Dizziness
- ☐ Hearing Impairment / Loss
- ☐ Heart Murmur
- ☐ Heart Surgery
  Type: _____
- ☐ Heart Trouble
  Type: _____
- ☐ Hepatitis
  Type: _____
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease / COPD
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Mobility Impairment
- ☐ NON-DENTAL Implants
  Type: _____
- ☐ Organ Transplants
  Type: _____
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Radiosurgery
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Visual Impairment
- ☐ Other Disease / Illness
  Type: _____
  _____

Sleep Apnea ____

_____ _____

Patient Signature **Date**

_____ _____

Doctor's Signature **Date**

Informed Consent to Treatment

Drugs and Medication
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).
(Initial: _____)

Changes in Treatment Plan
I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.
I give my permission to the dentist to make any/all changes and additions as necessary once they've been discovered and discussed. (Initial: _____)

X-Rays
I understand x-rays are necessary for proper diagnosis and treatment. (Initial: _____)

Fillings
I understand that care must be exercised in chewing on fillings, especially during the first 24 hours, to avoid breakage.
I understand that a more expensive filling may be required due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common aftereffect of a newly placed filling. (Initial: _____)

Local Anesthetic
Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to receive dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection. Risks include but are not limited to.' It is normal for the numbness to take time to wear off after treatment, usually two to three hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur. Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during dental treatment. (Initial: _____)

I understand that dentistry is not an exact science, and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction. I consent to the proposed treatment.
(Initial: _____)

General Consent to Treatment

1. I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee.
3. In general terms, the dental procedure(s) can include is not limited to:
    a. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride
    b. Application of resin "sealants" to the grooves of the teeth
    c. Treatment of diseased or injured teeth with dental restorations (fillings)
    d. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections
4. I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.
5. I certify that if I and/or my dependents have insurance coverage, I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
6. I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

7.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner, and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Patient Name (Print)

Patient or Parent | Guardian Signature

Date

ACKNOWLEDGEMENT FORM

I have received the "**Notice of Privacy Practices**" and have been provided an opportunity to review it.

_____ _____

Patient Name (Print) Patient Date of Birth

_____ _____

Parent | Guardian Name if Patient is a Minor (Print) Relationship to Patient

_____ _____

Signature Date

Cancellation / No Show Fee

Any appointment not cancelled within a 48 hour period will be charged $55 fee. No show appointments will be charged a $70 fee. If 3 or more appointments are missed, dismissal of practice is possible.

Patient Signature of agreement _____

Date _____