Patient Information and Medical History

Patient Name:______________________________ Social Security Number:__________________________

Date of Birth:______________________________ Gender:__________ Phone: ____________________

Address: ______________________________________ Email:________________________________

City: ____________________________________ State: __________ Zip: ______________________

Employer: ______________________________

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Referred by: ____________________ Emergency Contact Name & Phone: ___________________________

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Parent or guardian (if under 18): ______________________________ Phone: ____________________

Address: ____ SSN: _____________________

Employer: ____ Date of Birth: ________________

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Spouse: ____ Phone: ____________________

Address: ____ SSN: _____________________

Date of Birth: _______________

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Please answer each of the following:

1. Date of last physical examination __________________ Physicians name: ______________________
2. Have you been under the care of the physician in the past two years? ❑ No ❑ Yes, ____________________
3. Have you been hospitalized during the last two years? ❑ No ❑ Yes, ____________________
4. Are you allergic to (i.e., itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? ❑ No ❑ Yes, ____________________
5. Are you allergic to (i.e., itching, rash, swelling of hands, feet, or eyes) or made sick by any foods or any other non-medicinal items? ❑ No ❑ Yes, ____________________

Women:

- Are you pregnant? ❑ No ❑ Yes Weeks: ___
- Are you nursing? ❑ No ❑ Yes
- Are you taking birth control pills? ❑ No ❑ Yes

6. Check any of the following you have **had** or **have at present**:

❑ Heart Failure	❑ Heart Disease	❑ Angina Pectoris	❑ High Blood Pressure
❑ *Mitral Valve Prolapse	❑ *Any type of Transplant	❑ *Rheumatic Fever	❑ *Autism
❑ Heart Pacemaker	❑ *Heart Murmur	❑ Angina	❑ Cancer _________
❑ Stroke	❑ Heart Surgery	❑ Psychiatric Treatment	❑ ADD/ADHD
❑ Kidney Disorder	❑ Seizures/Epilepsy	❑ Diabetes	❑ Emphysema
❑ Tuberculosis (TB)	❑ Ulcers	❑ Sinus Problems	❑ Hay Fever
❑ Bruise Easily	❑ Asthma	❑ Radiation Treatment	❑ Chemotherapy
❑ Jaundice	❑ Allergies or Hives	❑ Fainting/Dizzy Spells	❑ Sickle Cell Disease
❑ Thyroid condition	❑ Arthritis	❑ HIV Positive, ARC, AIDS	❑ Alcoholism
❑ Drug addiction	❑ Glaucoma	❑ Cortisone Medications	❑ Hepatitis ________
❑ Liver Disease	❑ Cold Sores	❑ Blood Transfusion	❑ Bleeding Disorder
❑ Herpes	❑ *Any type of Implant	❑ Use of Tobacco Products	❑ Spina Bifida
❑ *Congenital Heart Defect	❑ Heart Attack Date ___________	❑ Developmental Delays	❑ *Artificial knee, hip or other joint
❑ Alzheimer's/Dementia	❑ Down Syndrome	❑ Parkinson's Disease	❑ Oral or IV Bisphosphonates

*Antibiotic premedication may be required prior to your appointment

7. Are there any other health concerns we should be aware of?

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8. Please list all medications that you are currently taking (including over the counter medications, vitamins, or herbal remedies:

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Dental Insurance Information:

Name of Insurance Company : ______________________________________ Phone: ______________________

Subscriber’s Name: _______________________ SSN: _________________ Date of Birth: __________________

Secondary Insurance Company: ______________________________________ Phone: ______________________

Subscriber’s Name: _______________________ SSN: _________________ Date of Birth: __________________

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Financial Responsibility: ❏ Self ❏ Other - Please complete information below

Name of Responsible Party: ______________________________________ Phone: ______________________

Relationship to Patient: ____________________ SSN: _________________ Date of Birth: __________________

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BELTRAMI, DIXON, WOODARD, DDS PLC (DBA COMMONWEALTH DENTISTRY) FINANCIAL POLICY REQUIRES PAYMENT AT THE TIME SERVICES ARE RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. Should my treatment be extensive, I may request additional information regarding financial plans. In the event that any balance on my account must be placed for collection, I agree to pay the collection agency fees up to 32%, reasonable attorney’s fees, and all court costs. I understand that all amounts over 30 days after treatment are subject to finance charge of 1.5% per month (18% annual rate) I am aware that should I fail to keep an appointment without giving 24 hour notice, I will be charged a broken appointment fee.

Patient - Guarantor(s) expressly waives the benefit of the homestead exemption laws of the Commonwealth of Virginia.
Patient - Guarantor(s) expressly grants Commonwealth Dentistry and any of its third-party business partners (current or future), the right to contact them via mobile phone, email, mail or text.

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Patient (or Guardians) Signature Today's Date