Prescription Medication

Patient Name: ________________________ DOB: ________________________

Medication	Dosage	Taken for

Broadway Dentistry
P.O. Box 160, 109 N. Main Street, Broadway, VA 22815
Telephone (540) 896-8151

Patient Registration form
Please Print

Your Information:

Your Full Name: ______________________ Today's Date: ______________________

Address ____

City ______________________ State ________ Zip Code ______________________

Your Social Security # ______________________ Your Birth Date ______________________

Sex ____________ Marital Status ______________ Home Phone # ______________________

Cell Phone # ______________________

E-Mail ____

How would you like to be contacted? ______________________________

Whom may we thank for referring you to our office? ______________________________

If Married Your Spouse's Information:

Spouse's Full Name: ______________________ Spouse's Social Security # ______________________

Spouse's Employer: ______________________ Spouse's position: ______________________

Spouse's Work Phone # ______________________ Spouse's Birth Date: ______________________

Employment Information: If Guarantor, please list your employment

Your Present Employer ____

Your Present Position ______________________ Work Phone # ______________________

How long have you worked there? ____________ Dental Insurance ______________________

Your Spouse's Employer ______________________ Work Phone # ______________________

Your Spouse's Position ____

How long have they worked there? ____________ Dental Insurance: ______________________

Dental Insurance Information:

Name of Insured: ______________________ Name of Insurance Co. ______________________

Policy number ______________________ Group number ______________________

Guarantor Information (If other than yourself):

Who will be responsible for paying for your dental treatment? ______________________

Relationship: ______________ Home Phone: ______________ Work Phone ______________

Address: ____

Social Security Number______________________

FEES ARE DUE WHEN SERVICE ARE RENDERED UNLESS OTHER WRITTEN ARRANGEMENTS ARE MADE.

We require 24-hour notice if you need to reschedule or cancel your appointment. We reserve the right to charge a fee for not giving a 24-hour notice if you fail to make your appointment. If you need to cancel a Monday appointment, notice needs to be given by Thursday morning.

In the event of default by the patient or guarantor on any payment due to Broadway Dentistry, the patient and guarantor agree to pay Broadway Dentistry, for all cost of collecting, including thirty-three and one third percent (33 1/3) attorneys' fees.

By signing this Policy, I acknowledge this will be in effect from the date signed and for all future appointments.

Signature: ______________________________ **Date:** ______________________

MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________________ Date of Birth_______________________________ Male__ Female__

Please answer each question. If any question answered "yes", please give explanation.

How would you rate your health? Good____ Fair ____ Poor____

Please list any medical condition for that you are being treated for or have been treated for.______________________

____

Physician Name: ____________________________ Date of last Physical Exam ____________________________________

MEDICAL HISTORY

Do you have/had any of the following?

___ Aids/HIV infection

___ Anemia

___ Arthritis

___ Blood Transfusion Date:_____

___ Cancer

If yes, are you receiving treatment? Y N

Which kind? Chemotherapy radiation

___ Convulsions/Epilepsy

___ Convulsions/Epilepsy

___ Emphysema or COPD

___ Hepatitis

___ Stroke

___ Thyroid Disease

___ GI Reflux/Heartburn

Cardiovascular Disease Yes No if yes, please specify:

____Angina

____Artificial heart value

____Artificial joints

____Congenital heart defect

____Damaged heart valves

____Heart attack

____Heart Murmur

____Heart Surgery

____ High Blood Pressure

____Low Blood Pressure

____Mitral Valve Prolapse

____Pacemaker

____Rheumatic Heart disease

____Rheumatic fever

____Chest pain/discomfort

____Other:______________________

Diabetes: Yes No if yes, please specify: Type I (Insulin Dependent) Type II controlled Uncontrolled

Have you ever had an artificial joint replacement or heart valve replacement? Yes No

If yes, does your surgeon require premedication?

Date of surgery/what was replaced?____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS

____ Antibiotics ____Blood thinners ____Blood pressure medication

____ Insulin/diabetes medication ____Nitroglycerin ____Aspirin ____ Heart medications

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

____Local anesthetics ____ Aspirin ____ Latex

____Sedatives ____ Codeine

____Penicillin/antibiotics ____ Sulfa

DENTAL HISTORY

Reason for today's visit ____________________

Whom may we thank for referring you?____________________

When was your last dental appointment? ____________ When did you have x-rays taken last? ____________

How often do you brush your teeth? ____________ Do you use fluoride? ____________

Do you use tobacco products? ____________ Do you want to stop? ____________

Do you have any of the following oral habits?

____ Thumb sucking

____ Nail biting

____ Clenching/Grinding

Do hot, cold or sweets cause discomfort? Yes No

Are you wearing any dental appliances? Yes No

Have you ever had a bad reaction to local anesthesia? Yes No

Do you have trouble breathing while laying down? Yes No

Have you ever had any serious trouble associated with dental treatment? If yes, please explain:

____

Is there anything else about your oral health you think we should know?

____

CONSENT FOR TREATMENT
RELEASE OF INFORMATION

I consent to treatment necessary for my medical care. I authorize the release of any medical/dental records to any health care provider I may be referred to, and to the insurance company or third party payer indicated and/or noted in my chart, if applicable. I understand that, unless I/patient specifically state otherwise, this may include information relation to HIV testing, substance abuse and psychological disorders that may be included in my medical/dental records. I acknowledge that information authorized to any entity other than a health care provider or health/dental plan may no longer be protected by the federal privacy law. I understand this authorization may be revoked in writing by me/patient at any time, except the extent that action has been taken in reliance on this authorization. Unless revoked, I confirm that this authorization will be in effect as long as I am under the cared of Broadway Dentistry and Associates. Fax transmittal of medical records is allowed if indicated.

I authorize Broadway Dentistry and Associates to release medical information regarding me to: (Name, telephone number, relationship to patient, example: mother, father, spouse, etc...please note that ONLY THE NAMES LISTED will be able to obtain medical information about you).

NAME______________________________ PHONE___________________________RELATIONSHIP________________________

NAME______________________________ PHONE___________________________RELATIONSHIP________________________

NAME______________________________ PHONE___________________________RELATIONSHIP________________________

NAME______________________________ PHONE___________________________RELATIONSHIP________________________

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND AUTHORIZATION FOR TREATMENT, RELEASE OF MEDICAL/DENTAL INFORMATION AND INSURANCE PAYMENTS. FURTHER, I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE OFFICE'S PATIENT CONFIDENTIALITY POLICY TO READ FOR MY INFORMATION AND TO KEEP FOR MY RECORDS.

____________________________________ ___________________________ _________________________________

PATIENT SIGNATURE PATIENT NAME PRINTED DATE

Patient Confidentiality Policy Received ____

Employee/Staff Initials _____________________________________ Date Checked/reviewed __________________________