Tuckahoe Family Dentistry

Adrian Avram D.D.S.

1006 PUMP RD., SUITE 101, RICHMOND, VA 23238
info@tuckahoedentistryva.com, Tel.: 804-740-0834, Fax: 804-740-4311

Please have your **INSURANCE CARD** and **DRIVER'S LICENSE** ready for us to scan.

PATIENT: **Title**: (Mr Mrs Ms Miss) **Suffix:** (Jr Sr) **Sex**: Male Female

First Name: _____ Middle Initial:_____ Last Name: _____

Address: _____City: _____ _____State: _____ Zip: _____

Cell #: (_____)_____ Work#: (_____)_____ Home#:(____)_____

Email:_____ Birth Date: ____/_____/_____ Social Security#: _____ /_____/_____

Emergency Contact Name: _____Phone: _____Relationship:_____

How did you hear about us:_____

PERSON RESPONSIBLE FOR ACCOUNT --- (NOT INSURANCE COMPANY)

(Skip if SAME as Above) : (Mr Mrs Ms Miss) **Suffix:** (Jr Sr) **Sex**: Male Female

First Name: _____Middle Initial:_____ Last Name:_____

Address: _____ City: _____ _____State: _____ Zip: _____

Cell #: (_____)_____ Work#: (_____)_____ Home#:(____)_____

Email:_____ Birth Date: _____/_____/_____ Social Security#: ___ /_____/_____

PRIMARY DENTAL INSURNCE **(Do you have SECONDARY INSURANCE? YES_____ NO_____)**

Insurance Name: _____Phone#: (_____)_____

Policy Holder Name: _____ Employer:_____

Birth Date: ____/_____/_____ Social Security#:_____/_____/_____ INS ID:_____

MISSED APPOINTMENT POLICY Due to the high cost of no show appointments, we will be obligated to charge you a **$50.00** fee if you do not call or cancel your appointment forty eight (48) business hours in advance. **INITIAL HERE:**_____

FINANCIAL AGREEMENT I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. **I understand that payment is due at the time of service unless prior arrangements have been made.** In the event payments are not received by agreed upon dates, I agree to pay 1 1/2% per month late charge (18% APR) I agree to pay for all collection cost plus attorney's fees equal to 33 1/3% of all sums due. **INITIAL HERE:**_____

Please sign that you have read and understand the above FINANCIAL and MISSED appointment policy.

SIGNATURE OF PATIENT/GUARANTOR: _____ **DATE:**_____

TUCKAHOE FAMILY DENTISTRY,PLLC

Adrian C. Avram DDS * 1006 Pump Rd, Ste 101, * Richmond,VA 23238 * 804-740-0834

Patient Name: Birth Date: Date Created:

Disclaimer

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

SIGNATURE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

DENTAL HISTORY

Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____

Date of most recent treatment (other than a cleaning) _____/_____/_____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

		YES	NO
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6.	Have you had any teeth removed or missing teeth that never developed?	☐	☐

GUM AND BONE

7.	Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐

TOOTH STRUCTURE

14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT

21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench your teeth in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS

33.	Is there anything about the appearance of your teeth that you would like to change?	☐	☐
34.	Have you ever whitened (bleached) your teeth?	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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HIPAA CONSENT FORM (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1995)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the **Health Insurance Portability and Accountability Act of 1995 (HIPAA).**

I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

* **Treatment** (including direct or indirect treatment by other healthcare providers involved in my treatment).

* **Obtaining payment from third party payers** (e.g. my insurance company).

* **The day-to-day healthcare operations of your practice**.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contain a more complete description of the uses and disclosures of my protected health information, and my rights under **HIPAA**. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However any use of disclosures that occurred prior to that date I revoke this consent is not affected.

Patient Name_____ **Parent or Legal Guardian Name** _____

Patient or Legal Guardian Signature_____ **Date:** _____

NOTICE OF DEEMED CONSENT TO HIV, HEPATITIS B, HEPATITIS C BLOOD TESTING

A Virginia law was enacted in 1989 that allows health care providers to test their patients for HIV antibodies, Hepatitis B, and Hepatitis C when a health care worker is exposed to the blood or bodily fluids of a patient which may transmit human immunodeficiency virus (HIV) the virus which cause AIDS or Hepatitis B.

Because this is a law, in the event of such exposure, you will be deemed to have consented to such testing and to have consented to the release of test results to the exposed worker.

Except in emergencies, you will be informed before any of your blood is tested for HIV antibodies, Hepatitis B, and Hepatitis C, and testing will be explained to you. You will be given the opportunity to ask any questions you may have.

You will be provided with the test results and appropriate counseling. Test results, if positive, are required by law to be reported to the Virginia Department of Health.

I certify that I have read and fully understand that this consent will remain in effect as long as my dependent or I receive care from Tuckahoe Family Dentistry dental practices.

Patient Name_____ **Parent or Legal Guardian Name** _____

Patient or Legal Guardian Signature_____ **Date:** _____

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PATIENT/ GUARANTOR FINANCIAL AGREEMENT

FINANCIAL AGREEMENT

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. **I understand that payment is due at the time of service unless prior arrangements have been made**. In the event payments are not received by agreed upon dates, I agree to pay 1 1/2% per month late charge (18% APR). I agree to pay for all collection cost plus attorney's fees equal to 33 1/3% of all sums due. **INITIAL HERE**_____

REGARDING DENTAL INSURANCE

We are happy to assist you in maximizing your dental insurance benefits. It is important to understand that the agreement regarding your dental benefits is between you, your employer (if applicable), and your insurance company. Completing insurance claims is a courtesy we extend in an effort to save you time and to facilitate payment to our office. Although we are willing to submit dental claims on your behalf with the information you have provided us, it is important that you understand that this does not eliminate your financial obligation to our practice. Our practice does not guarantee you that your insurance company will assist you with payment for the treatment you receive from our practice. Please understand that all changes incurred belong to you, contact y our insurance company directly for benefits specific to you.

REGARDING PAYMENT

We will estimate your portion of any treatment recommended, which is due at the time of service. This is only an estimate, an additional copayment may be due and you are responsible for the unpaid balance. We accept Cash, Debit/Credit cards, Care Credit, and Checks. You may be asked to pay commitment fee when scheduling an appointment, this will be deducted from your final payment.

MINOR PATIENTS

The parent/guardian of the minor patient(s) is responsible for full payment including any estimated copayment or commitment fee.

MISSED APPOINTMENTS / CANCELLATIONS

Due to the high cost of no show or late cancel appointments, we will be obligated to charge you a **$50.00 fee** if you do not call or cancel your appointment forty eight (48) business hours in advance. **INITIAL HERE**_____

SIGNATURE OF PATIENT/GUARANTOR_____ **DATE**_____