VACCA
• FAMILY DENTISTRY •
A Division of Central Virginia Dental Care, PLC

NEW PATIENT INFORMATION FORM

Name _____ Preferred Name _____

Date of Birth _____ Social Security # _____Marital Status_____

Street Address _____ City _____ State _____ Zip _____

Phone # (H) _____(W) _____ (C) _____E-mail _____

Employer _____ Address _____

Emergency Contact _____ Phone # _____Relationship to Patient _____

If under 18 years of age, person responsible for account:

Name _____ Cel #_____ Work # _____

Address _____ Social Security # _____Relationship to Patient_____

How did you hear about us? Check all that apply: __Internet Search __Friend/Family Referral __Doctor Referral __ Insurance

__ Social Media __ Magazine Other _____

INSURANCE INFORMATION

Primary

Subscriber's Name _____Date of Birth _____ Employer_____

Insurance Company _____ Insurance Phone # _____

Subscriber ID# _____ ID #_____Group #_____

Secondary

Subscriber's Name _____Date of Birth _____ Employer_____

Insurance Company _____ Insurance Phone # _____

Subscriber ID# _____ ID #_____Group #_____

FINANCIAL INFORMATION

We are happy to file any dental insurance; however, it is the patient's responsibility for any balances not paid for by their insurance. If insurance information is not provided, payment for services is due at the time services are rendered. Accepted forms of payment are Visa, MasterCard, Discover, cash, and check. Any unpaid balance over 30 days is subject to a 1.5% per month finance charge. Any unpaid balance over 90 days is subject to be turned over to a collection agent along with a 35% collection fee and $10 postage fee. If legal action is required on an account, a $50 fee will apply. By signing this form, I give my authorization to furnish the required information to my insurance provider and assign benefits to this office. I hereby certify that all of the above information is true and correct to the best of my knowledge and agree to accept the financial responsibility for any balances due on my account.

Signature _____ Date _____

PRIVACY INFORMATION

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. I have been offered or received a copy of the office Notice of Privacy Practices and have been given full opportunity to read and consider the contents. I also understand that your office will not be able to file any insurance claims unless this consent is signed.

Signature _____ Date _____

Approximate date of last dental visit _____ Have you ever had a bad dental experience? Y N

Reason for your visit with us today: _____

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HEALTH HISTORY FORM

Are you under a physician's care now?	O Yes	O No	If yes, _____
Have you been hospitalized or had a major operation?	O Yes	O No	If yes, _____
Have you ever had a serious head or neck injury?	O Yes	O No	If yes, _____
Are you taking any medications, pills, or drugs?	O Yes	O No	If yes, _____
Are you on a special diet?	O Yes	O No	If yes, _____
Do you use tobacco?	O Yes	O No	If yes, _____
Are you on an aspirin regimen?	O Yes	O No	If yes, _____
Do you need to be pre-medicated?	O Yes	O No	If yes, _____

Women: Are you… O Pregnant/Trying to get pregnant? O Nursing? O Taking oral contraceptives?

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Sulfa Drugs
O Local Anesthetics O Other? _____

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

AIDS/HIV Positive	O Yes O No	Emphysema	O Yes O No	Irregular Heartbeat	O Yes O No
Alzheimer's Disease	O Yes O No	Epilepsy or Seizures	O Yes O No	Kidney Problems	O Yes O No
Anemia	O Yes O No	Excessive Bleeding	O Yes O No	Leukemia	O Yes O No
Angina	O Yes O No	Excessive Thirst	O Yes O No	Low Blood Pressure	O Yes O No
Arthritis / Gout	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Liver Disease	O Yes O No
Artificial Heart Valve	O Yes O No	Frequent Headaches	O Yes O No	Lung Disease	O Yes O No
Artificial Joint	O Yes O No	Frequent Cough	O Yes O No	Mental/Psychiatric Care	O Yes O No
Asthma	O Yes O No	Glaucoma	O Yes O No	Mitral Valve Prolapse	O Yes O No
Blood Disease	O Yes O No	Hay Fever	O Yes O No	Radiation Treatments	O Yes O No
Blood Transfusion	O Yes O No	Hepatitis A	O Yes O No	Renal Dialysis	O Yes O No
Breathing Problems	O Yes O No	Hepatitis B or C	O Yes O No	Rheumatic Fever	O Yes O No
Bruise Easily	O Yes O No	Hemophilia	O Yes O No	Rheumatism	O Yes O No
Cancer	O Yes O No	Herpes	O Yes O No	Scarlet Fever	O Yes O No
Chemotherapy	O Yes O No	High Blood Pressure	O Yes O No	Sinus Trouble	O Yes O No
Chest Pains	O Yes O No	High Cholesterol	O Yes O No	Shingles	O Yes O No
Cold Sores/Fever Blister	O Yes O No	Hives or Rash	O Yes O No	Stroke	O Yes O No
Congenital Heart Dis.	O Yes O No	Hypoglycemia	O Yes O No	Tuberculosis	O Yes O No
Cortisone Medicine	O Yes O No	Heart Attack/Failure	O Yes O No	Tumors or Growths	O Yes O No
Diabetes	O Yes O No	Heart Murmur	O Yes O No	Osteoporosis	O Yes O No
Drug Addiction	O Yes O No	Heart Disease/Trouble	O Yes O No	Pain in Jaw Joints	O Yes O No
Easily Winded	O Yes O No	Heart Pacemaker	O Yes O No	Ulcers	O Yes O No

Have you ever had a serious illness not listed above? O Yes O No If yes, _____

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 _____