

Welcome

Brown, Reynolds, Snow Dentistry, 6901 Patterson Avenue, Richmond, VA 23226, (804) 288-5324

ABOUT YOU

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ Male Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ Single Married Divorced Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: (____) _____ Pager/Car #: (____) _____ Work Phone #: (____) _____ Ext: _____ Driver License #: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (____) _____ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Drivers License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Drivers License #: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Have you experienced problems associated with any previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is Good Fair Poor

Do you floss daily? Yes No Brush daily? Yes No

Type of bristles on your toothbrush? Hard Medium Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? Yes No

If yes, what? _____

Would you like fresher breath? Yes No Whiter teeth? Yes No

Do your gums ever bleed? Yes No Ever Itch? Yes No

Have you ever had periodontal disease? Yes No

Do you have any loose teeth? Yes No

Are your teeth sensitive to heat, cold, or anything else? _____

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most & least about any dentist you have seen? _____

Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Address: _____
Street City State Zip

Phone #: (____) _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions: _____

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes No

Week #: _____ Are you nursing? Yes No

Are you taking any of the following?

Y N Acetaminophen	Y N Bisphosphonates (Fosamax)	Y N Digitalis/Heart Medication	Y N Steroids/Cortisone
Y N Antibiotics	Y N Blood Thinners	Y N Insulin/Diabetes Drugs	Y N Thyroid Medicine
Y N Antihistamines	Y N Blood Pressure Medication	Y N Nitroglycerin	Y N Tranquilizers
Y N Aspirin	Y N Cold Remedies	Y N Recreational Drugs	Have you ever taken Phen-Fen? Also known as Redux or Pondimin. <input type="checkbox"/> Yes <input type="checkbox"/> No

Are you taking any prescription, over-the-counter or herbal drugs not listed above? Yes No If yes, please list each one: _____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Congenital Heart Defect	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Alcohol Abuse	Y N Diabetes	Y N Heart Surgery	Y N Osteoporosis/Osteopenia	Y N Steroid Therapy
Y N Anemia	Y N Difficulty Breathing	Y N Hemophilia	Y N Pacemaker	Y N Stroke
Y N Arthritis	Y N Drug Abuse	Y N Hepatitis	Y N Persistent Cough	Y N Thyroid Problems
Y N Artificial Bones/Joints	Y N Emphysema	Y N Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Artificial Valves	Y N Epilepsy	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Asthma	Y N Fainting Spells	Y N HIV+/AIDS	Y N Rheumatic Fever	Y N Ulcers
Y N Blood Transfusion	Y N Fever Blisters	Y N Hospitalized for Any Reason	Y N Rheumatoid Arthritis	Y N Venereal Disease
Y N Cancer	Y N Glaucoma	Y N Kidney Problems	Y N Scarlet Fever	
Y N Chemotherapy	Y N Hay Fever	Y N Liver Disease	Y N Seizures	
Y N Chicken Pox	Y N Headaches	Y N Low Blood Pressure	Y N Shingles	
Y N Colitis	Y N Heart Attack	Y N Lupus	Y N Sickle Cell Disease	

Please list any serious medical condition(s) that you have experienced: _____

AUTHORIZATIONS

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the financial manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____

Date _____