

Welcome!
540-743-4810



156 E. Main St.
Luray, VA 22835
www.lurayfamilydental.com

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Date of Birth _____

Soc. Sec. # _____ not required for children

Address _____ City/State/Zip _____

Home Ph# _____ Cell Ph# _____ Email _____

CHECK ONE Male Female

MINOR PATIENTS Responsible Party MUST BE PRESENT (we will not bill third party)

Responsible Party: _____ Ph# _____

Address _____

Emergency Contact Name _____ Relationship _____

Ph# _____

Whom may we thank for referring you? _____

Medical History

Physician name _____ Ph# _____ Date of last visit _____

Have you had any serious illness or operations? No Yes If yes, describe _____

Have you ever had a blood transfusion? No Yes If yes, give appx. dates _____

Have you ever taken Fen-Phen/Redux? No Yes

Have you ever used a bisphosphonate medication? No Yes (EG: Fosamax, Actonel, Atelvia, Didronel, Boniva)

WOMEN: Are you pregnant? No Yes Nursing? No Yes Birth Control? No Yes

Please list any medications:

Please list any allergies:

Please complete reverse side

Please check if have had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> AID/HIV Positive | <input type="checkbox"/> Hemophilia/Abnormal Bleeding | <input type="checkbox"/> Surgical implant |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Kidney disease, malfunction | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Atopic (allergy prone) | <input type="checkbox"/> Material allergies (<i>latex, wool, metal, chemicals</i>) | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Mitral valve prolapsed | |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Nervous problems | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pacemaker/Heart surgery | |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Psychiatric care | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Rapid weight gain or loss | |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Radiation treatment | |
| <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Respiratory disease | |
| <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Rheumatic/Scarlet fever | |
| <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Shingles | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Skin rash | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Spina bifida | |
| <input type="checkbox"/> Food allergies | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Glaucoma | | |
| <input type="checkbox"/> Headaches | | |
| <input type="checkbox"/> Heart murmur | | |
| <input type="checkbox"/> Heart problems | | |

Other: _____

Describe _____

PROVIDERS ONLY

Medical history reviewed by:

Dr _____

Date _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medial status, I will inform the dentist.

I authorize the use of this signature on all insurance submissions.

I authorize Luray Dental to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____

Date _____

Thank you