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 **STATUS** ☐ Single ☐ Married ☐ Child ☐ Other

Patient Employed by ____________________________ **Business Ph#** _________________

Business Address ____

Emergency Contact Name _________________________________ **Relationship** _________________________

Ph# _________________________________ **Email** _________________________________

Whom may we thank for referring you? ____

Dental Insurance

Subscriber: ☐ Self ☐ Spouse/Other *IF SELF, Skip to next section: Insurance Details*

Subscriber Name _________________________________**Birth date** ___________ **Soc. Sec.#** ______________

Address (if different from patient) ____ **Ph#** ________________

Subscriber Employed by ______________________________ **Business Ph#** ______________________________

Insurance Details: **Insurance Company** _____________________________ **Ph#** _________________________

Contract/Group# __________________________________ **Subscriber ID#** ____________________________

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ Yes ☐ No *If NO, Skip to next page*

Subscriber Name ______________________________ **Birth date** ______________ **Soc. Sec.#** ______________

Subscriber Employed by ________________________________ **Business Ph#** ____________________________

Insurance Company ____ **Ph#** ___________________________

Contract/Group# _________________________________ **Subscriber ID#** ______________________________

Please complete next sheet

Dental History

What would you like us to do today? ___________________________

Are you in dental discomfort today? ______

Former Dentist ________________________ Ph# _______________ Dentist's Email ________________________

Address____ City ____________________ State _____ Zip __________

Date of last dental care ______________________________ Date of last x-rays _____________________________

Please check if you've had any problems with the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Grinding or clenching teeth
- ☐ Food collection between teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sores or growths in mouth
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets

How often do you brush? ______________________ Floss? _______________________________

How do you feel about the appearance of your teeth? ____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?
☐ No
☐ Yes *Please explain* ____

Other information about your dental health or previous treatment _______________________________________

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:

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Please list any allergies:

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Please complete other side

Please check if have had any of the following:

- ☐ AID/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems

Describe ______________________

- ☐ Hemophilia/Abnormal Bleeding
- ☐ Herpes
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaw pain
- ☐ Kidney disease, malfunction
- ☐ Liver disease
- ☐ Material allergies *(latex, wool, metal, chemicals)*
- ☐ Mitral valve prolapsed
- ☐ Nervous problems
- ☐ Pacemaker/Heart surgery
- ☐ Psychiatric care
- ☐ Rapid weight gain or loss
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic/Scarlet fever
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Spina bifida
- ☐ Stroke
- ☐ Surgical implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease or malfunction
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer/Colitis
- ☐ Venereal disease

Other:___________________

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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 insurance company indicated on this form to pay to Luray Dental all insurance benefits otherwise payable to me for services rendered. 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