Wendy M. Moore, DDS

9449 Grover Drive, Suite 100
King George, VA 22485

Tell: (540) 775-5774
Fax: (540) 775-6538
Email: drwendy@wendymooredds.com
Web: www.wendymooredds.com

Patient Information

Patient Name: _____ Date:_____
Last, First MI (Preferred Name)

Gender: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____
Social Security #: _____ Birth Date: _____

Phone Home: _____ Work: _____ Cell: _____
Best Contact Location: _____
E-Mail Address:_____

Mailing Address:_____
Street Apartment #

_____
City State Zip Code

Street Address: _____
Street Apartment #

_____
City State Zip Code

Person to contact in case of emergency: _____ Phone: _____

Spouse and/or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone Home: _____ Work: _____ Cell_____
E-Mail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address:_____
Street Apartment #

_____
City, State Zip Code

Patient Name: _____ Date: _____

Insurance Information

Primary

Name of Insured: _____ is the insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Parent Signature

I allow my child to receive treatment from the Doctor and the staff. I allow my child to have the appropriate x-rays taken and fluoride treatment given.

Signature: _____ Date: _____

Authorization for Testing

Any patient who exposes a health care provider or his/her employee/agent to body fluid in any manner which may transit the human immunodeficiency virus (HIV), Hepatitis B or C virus is deemed to have consented HIV, Hepatitis B and C testing and disclosure of the results to the person exposed. The deemed consent also applies to a health care provider who exposes a patient to body fluid in the above stated manner.

If an employee is exposed to my bodily fluid in any way that will transmit disease I agree to be tested. The caregiver also agrees to be tested if exposure occurs in any manner that may transmit disease to the patient.

_____ _____
Patient and/or Guardian Date

Authorization for Photographs

I, (please print) _____, give Dr. Wendy M. Moore, DDS permission to record my image and grant Dr. Wendy M. Moore, DDS all rights to use these photographs in any medium for educational, promotional, advertising, or other purposes that support the promotion of dentistry.

I Understand the above and agree to its terms.

Patient/Guradian Signature:_____

20170303

Date:_____

3

Dental History

Former Dentist: _____
Reason for today's visit: _____
Date of last exam _____ Date of last dental X-rays _____
Have you ever been diagnosed with Periodontal Disease? _____ When? _____
How was it treated? _____

Is there an immediate family member(s) who currently has or had gum problems in the past? (E.g. Your mother, Father, or siblings): ☐Yes ☐ No

Have you noticed any of the following signs of gum disease?

☐ Bleeding gums during brushing
☐ Red, swollen or tender gums
☐ Gums that have pulled away from the teeth
☐ Persistent bad breath
☐ Pus between the teeth and gums
☐ Loose or separating teeth
☐ Change in the way your teeth fit together
☐ Food catching between the teeth

Is it important to keep your teeth for as long as possible? _____
If you have missing teeth; why have you not replaced them? _____
Do you now or have you ever used tobacco or other types of products:

Type	Amount per Day	Years used?	When did you quit?

Have you returned from a foreign country in the last 30 days? : ☐Yes ☐ No
If yes, are you feeling flu like symptoms?: ☐Yes ☐ No

Health Information

Have you ever had any of the following? Please check those that apply:

☐ Acid Reflux	☐ Fever Blisters	☐ Phen/Phen Use
☐ Aids	☐ Fibromyalgia	☐ Are you pregnant now?
☐ Allergies	☐ Glaucoma	☐ Psychiatric Care
☐ Anemia	☐ Growths	☐ Recreational Drug Use
☐ Arthritis	☐ Hay Fever	☐ Radiation Treatment
☐ Artificial Heart Valve	☐ Head Injuries	☐ Respiratory Problems
☐ Artificial Joints	☐ Heart Disease	☐ Rheumatism
☐ Asthma	☐ Heart Murmur	☐ Scarlet Fever
☐ Back Problems	☐ Hepatitis A,B,C.D	☐ Seizures
☐ Bisphosphonate	☐ HIV	☐ Shortness of Breath
☐ Blood Clots	☐ Hypoglycemia	☐ Sinus Problems
☐ Blood Disease	☐ Irregular Heart Beat	☐ Sleep Apnea
☐ Blood Problems	☐ IV Medications	☐ Snoring
☐ Blood Thinners	☐ Jaundice	☐ Stroke
☐ Bruise Easily	☐ Kidney Problems	☐ Sulfa Allergy
☐ Cancer	☐ Latex Allergy	☐ Thyroid Problems
☐ Chemo TX	☐ Liver Problems	☐ Tobacco Habit
☐ Circulatory Problems	☐ Low Blood Pressure	☐ Tuberculosis
☐ Codeine Allergy	☐ Mental Disorders	☐ Tumors
☐ Cold Sores	☐ Migraines	☐ Tobacco Habit
☐ Cortisone Injections	☐ Mitral Valve Prolapse	☐ Tuberculosis

☐ Diabetes	☐ Osteopenia	☐ Tumors
☐ Emphysema	☐ Osteoporosis	☐ Ulcers
☐ Excessive Bleeding	☐ Pacemaker	☐ Venereal Disease
☐ Fainting	☐ Penicillin Allergy	☐ Other

4

Are you allergic to any medications or substance? Please check appropriate boxes.
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____
Are you currently taking any medications or vitamins? _____
Have you had Oral and/or IV treatment with BISPHOSPHONATE (i.e. Fosamax, Actenol, etc)?
_____
Do you need to be Pre-medicated (i.e. Heart, replacement of hip, knee, etc.)? ☐Yes ☐No
What are you traditionally pre-medicated with: ☐ Amoxicillin 500 mg
☐ Clindamycin 150 mg
☐ Cephalexin 500 mg
☐ Other _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:

Any additional information that you would like to disclose:
_____

It's Your Smile

Have you ever had braces? _____
Do you wear a sports or night guard? _____
Are you pleased with the appearance of your smile? _____
If not, what would you like to change? _____
Are you pleased with their function? _____
Do you sip soda, juice, coffee or tea throughout the day? _____
Do you have any allergies to jewelry? _____
Do you use an electric toothbrush? _____
Are you under a lot of stress? _____
Do you snore? _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 2015 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Name: _____

Patient/Guardian Signature:_____ Date:____

Relationship to Patient: ☐ SELF ☐ PARENT ☐ GUARDIAN ☐ OTHER (PLEASE EXPLAIN)

I give permission for the following communications to be used by Dr. Wendy M. Moore, DDS:

☐ Cell phone: ☐ Text Message reminders permitted

☐ Home phone ☐ Work ☐ E-Mail:

I give permission for Dr. Wendy M. Moore, DDS to disclose their identity when calling; to anyone who may answer

my phone. ☐Y ☐N ☐ Other (Please explain)

I grant permission for Dr. Wendy M. Moore, DDS to leave a message on:

☐ Home phone ☐ Work Phone

☐ Cell Phone ☐ With any person who may answer when calling the home or cell phone

☐ None of the above (Please explain)

I would like the following person(s) to have access to my personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

_____

_____

_____

Is there anyone you *do not* want us to speak to concerning your dental health?

_____

_____

_____