

# Welcome to Battlefield Dental of Fredericksburg!

5996 Plank Road, Fredericksburg, VA 22407 Phone: (540)412-6793

## Patient Information:

Name: First \_\_\_\_\_ Last \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip \_\_\_\_\_ - \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone (preferred #): \_\_\_\_\_

**\*\*\* Please keep in mind we kindly ask you confirm your appointments via text message or email; we no longer call to confirm appointments.**

E-mail: \_\_\_\_\_ ☐ I would like to receive correspondence via e-mail

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Driver's Lic: \_\_\_\_\_

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

**\*\*Referred By:** \_\_\_\_\_ **Previous Dentist:** \_\_\_\_\_ **Emergency Contact:** \_\_\_\_\_

(How did you hear about our office)

**Emergency Contact #:** \_\_\_\_\_

Name of Employer: \_\_\_\_\_

## Responsible Party (if different from above):

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_ State/Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_ Driver's Lic: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

## Primary Insurance Policy Holder:

Name: First \_\_\_\_\_ Last \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Employer: \_\_\_\_\_

ID# or Soc Sec: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Alt Phone #: \_\_\_\_\_

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No \_\_\_\_\_

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: \_\_\_\_\_

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problem <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

Comments: \_\_\_\_\_

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 \_\_\_\_\_ DATE \_\_\_\_\_



**Battlefield Dental of Fredericksburg, 5996 Plank Road, Fredericksburg, VA 22407**

**Phone: (540)412-6793, Fax: (540)412-6802**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- **Dental Treatment, including direct or indirect treatment by other healthcare providers involved in my treatment**
- **Obtaining payment from third party payers (i.e. my insurance company)**
- **The day to day healthcare operations of your practice**

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent, is not affected.

**Print Patient Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

\*You May Refuse to Sign This Acknowledgment\*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**Patient Agreement and Financial Policy**

Payment for services are due at the time services are rendered. For your convenience, we accept cash, checks, money orders, VISA, Mastercard, Discover, and Care Credit.

We will file your insurance claims as a courtesy, however you remain responsible for payments not covered or rejected. Please familiarize yourself with your dental plan and any limitations and maximums that may apply to your policy.

Returned checks will be charged a \$50.00 handling fee.

We make every effort to schedule appointments that are the most convenient for you and that fit your personal schedule. *Because we do not schedule several appointments at the same time, all appointments are reserved exclusively for you.* In return, we ask that you make every effort not to change your reserved dental appointment.

A charge of \$20 per half hour of appointment time will be incurred for missed appointments and appointments canceled within a 48 hour (2 business days) advanced notice.

It is our policy to collect 10% (before insurance) of any appointments over 2 hours in length. If the appointment is kept, the down-payment will be credited towards the payment due for those services performed. If less than 2 business days notice is given to cancel or reschedule the appointment, the down-payment is non-refundable.

Battlefield Dental of Fredericksburg is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for this area. Thank you for understanding our payment policy. If you have any questions or concerns, please call our office for an explanation.

I hereby confirm that I have read the above payment policy and agree to abide by its guidelines. I also authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I understand that payment is due at the time of service and that failure to pay amounts due will result in my account being placed with a collection agency. In the event that my account is referred to an attorney/collection agency I hereby agree to pay all collection/attorney fees and any other cost of collections.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Printed name:** \_\_\_\_\_



# PatientConnect



*We have a great new service for you!*



**Request appointments online**



**Get email and text message  
appointment reminders**



**Be alerted when you're due  
for your next check-up**



**Receive special discounts and  
promotions from our office**



**Access your appointment and  
treatment history online**



**Pay Your Bills  
Online**