Virginia Surgical Arts, LLC
www.virginiasurgarts.com

PATIENT Name ______________________/____________/__________________ Nickname______________________
(first) (middle) (last)

Address_____________________________/__________________/______/____________________
(street) (city) (state) (zip)

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

Birthdate ____________ Age_____ Sex ☐M ☐F SSN____________________________

If Student: ☐ Full-time ☐ Part-time School______________________________________

Employer_______________________________Occupation_________________________________

Home # ( ) ____________ Cell # ( )______________ Work # ( )_____________Email__________________

PHYSICIANS (Full names please)

Referred by:______________________________________ Phone # ( ) ______________________________

General Dentist ___________________________________ Phone # ( ) ______________________________

Orthodontist ______________________________________Phone # ( ) ______________________________

Family Physician ___________________________________Phone # ( ) ______________________________

SPOUSE PARENT OR GUARDIAN Name ____

Address (if different) ____
(no. & street) (city) (state) (zip)

Birth date ______________ Marital Status_______________ SSN_________________

Employer__________________________________ Occupation_____________________________

Home # ( )______________ Cell # ( )_________________ Work # ( )______________ Email__________________

EMERGENCY CONTACT – friend/relative (not living with you)

Name ____Relation to Patient _________________________

Home # ( )______________ Cell # ( )________________ Work # ( )______________ Email__________________

DENTAL INSURANCE (PLEASE PROVIDE INSURANCE CARD & COMPLETE THIS SECTION)

Insurance Co. ______________________________________ Phone # ( )_____________________________

Insured's Name (if different than patient) ____

Birth date_____________ Relation to patient___________________ SSN________________Policy #_____________________

MEDICAL INSURANCE (PLEASE PROVIDE INSURANCE CARD & COMPLETE THIS SECTION)

Insurance Co. ______________________________________Phone #( )_____________________________

Insured's Name (if different than patient) ____

Birth date_____________ Relation to patient___________________ SSN________________Policy #_____________________

ARE YOU CURRENTLY APPROVED FOR FINANCING WITH: CAPITAL ONE __ CARE CREDIT __

AUTHORIZATION AND RELEASE FOR SERVICES RENDERED

I authorize the physician or healthcare professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as necessary for proper surgical care. I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment to be used by the doctor/interdisciplinary team members for scientific presentation or literature. I authorize Virginia Surgical Arts to release any information including the diagnosis and records of any treatment or examination rendered to me/my child during the period of such dental/medical care to third party payors, other entities and/or health practitioners.

_______________________________ ____

Signature of Patient **Signature of Guardian (if minor)** **Date**

Date___________________

MEDICAL AND DENTAL HISTORY

Patient's Name____ Male ☐ Female ☐

Birth Date_____________________ Age_____________ Weight__________ Height__________________

Patient's Current Dentist____________________________________ Date of last appt_______________

Patient's Current Physician__________________________________ Date of last appt_______________

Referred to our office by ☐ Self ☐ Friend - Name:_____________________________ ☐ Dentist ☐ Physician ☐ Yellow Pages

All past medical/dental history is important for you optimal care. Please take time to be accurate and thorough in answering the following question. Space has been allowed on the bottom of this form for you to explain any complex medical problems or concerns.

Please list your reason for this visit____

Describe anything that bothers you about your physical appearance that you would like to address_______________________________________

____

Please list any medical problems you have____

____

PLEASE LIST CURRENT MEDICATIONS (including non prescription/alternative/herbal) ____

____

PLEASE LIST ALL DRUG ALLERGIES (past and present)____

PLEASE LIST ALL PREVIOUS SURGERIES OR HOSPITALIZATIONS____

____

Please check all conditions that apply with a checkmark to indicate YES

- ☐ High Blood Pressure
- ☐ Chest pains or heart attack
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Shortness of breath or swollen ankles
- ☐ Heart trouble, murmur, mitral valve prolapse
- ☐ Prosthetic devices (heart, valve, hip, etc)
- ☐ Lung diseases (TB, emphysema, etc)
- ☐ Allergies or hay fever
- ☐ Sinus problems
- ☐ Mouth breathing or excessive snoring
- ☐ Ulcers or stomach problems
- ☐ Diabetes
- ☐ Hepatitis or liver disease
- ☐ Kidney or bladder disease
- ☐ Thyroid problems
- ☐ Arthritis or rheumatism
- ☐ Cancer (type & year)
- ☐ Serious illness not listed (list below)
- ☐ Subject to prolonged bleeding or bruise easily
- ☐ Glaucoma
- ☐ Epilepsy, convulsions, or seizure history
- ☐ Psychiatric therapy or emotional problems
- ☐ Sexually transmitted disease
- ☐ Pregnant
- ☐ Taking birth control pills
- ☐ Asthma
- ☐ Use tobacco (type & how much?)
- ☐ Consume alcoholic beverages?
- ☐ Pain, popping, catching, locking in jaw joints
- ☐ Clench or grind your teeth?
- ☐ Wake up with sore jaws?
- ☐ Frequent headaches (how many per week?
- ☐ Dizziness, ringing, pain in ears?
- ☐ Tenderness or stiffness in the jaw, neck, or back
- ☐ History of TMJ (jaw joint) problems
- ☐ Previous oral surgery
- ☐ Excessive fear of dental treatment
- ☐ Fever blisters or mouth ulcers
- ☐ Wear contact lenses

Please use this space to expand on the above information or add anything else you feel is important

The above information is accurate and complete to the best of my knowledge

Patient Signature____Date: ______________

IF MINOR - Parent or Guardian Signature____Date:_______________Dr's initials:____________

Date UPDATED: ____________________________Patient initials: __________________ Date: ______________Dr's initials ________________