Virginia Surgical Arts, LLC
www.virginiasurgicalarts.com

PATIENT

Name _____ _____ _____ **Nickname**_____
FIRST M.I. LAST

Address_____ _____ _____ _____
STREET CITY STATE ZIP

Home # ( )_____ **Cell #** ( )_____ **Work #** ( )_____**Email**_____

Birth date _____ **Age** _____ **Sex** ☐**M** ☐**F** **Please circle best contact number above.**

Social Security Number _____ **Marital status**: (Please Circle) Single Married Widowed Divorced Separated

Student ☐Full-time ☐Part-time **School**_____

Employer _____ **Occupation** _____

PERSON RESPONSIBLE FOR ACCOUNT (NOT INSURANCE SUBSCRIBER/PERSON RESPONSIBLE MUST BE HERE TO SIGN FORMS) **If self, write "Self" and skip to next section.**

Name _____ _____ _____ **Relation to Patient** _____
FIRST M.I. LAST

Address_____ _____ _____ _____
STREET CITY STATE ZIP

Home # ( )_____ **Cell #** ( )_____ **Work #** ( )_____ **Email**_____

Social Security Number _____ **Birth date** _____ **Age** _____ **Sex** ☐**M** ☐**F**

Employer_____ **Occupation**_____

EMERGENCY CONTACT

Name _____**Relation to Patient** _____

Home # ( )_____ **Cell #** ( )_____ **Work #** ( )_____ **Email**_____

DENTAL INSURANCE-PRIMARY (PLEASE PROVIDE INSURANCE CARD & COMPLETE THIS SECTION, IF NO INSURANCE PUT N/A)

Insurance Co. _____ **Employer** _____

Subscriber's Name _____ **Relation to patient**_____

Birth date _____**SSN** _____**Policy #** _____**Group #**_____

DENTAL INSURANCE-SECONDARY (PLEASE PROVIDE INSURANCE CARD & COMPLETE THIS SECTION, IF NO INSURANCE PUT N/A)

Insurance Co. _____ **Employer** _____

Subscriber's Name _____**Relation to patient** _____

Birth date _____**SSN** _____**Policy #** _____**Group #** _____

MEDICAL INSURANCE (PLEASE PROVIDE INSURANCE CARD & COMPLETE THIS SECTION, IF NO INSURANCE PUT N/A)

Insurance Co. _____**Employer** _____

Subscriber's Name _____**Relation to patient**_____

Birth date _____**SSN** _____**Policy #** _____**Group #**_____

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 payers, other entities and/or health practitioners.

_____ _____ _____
Signature of Patient **Signature of person responsible for account (if different from patient)** **Date**

Date_____

MEDICAL AND DENTAL HISTORY

Patient's Name_____ **Weight**_____ **Height**_____

Current Dentist_____ **Telephone #** _____ **Date of last appt**_____

Current Physician_____ **Telephone #** _____ **Date of last appt**_____

Pharmacy Name: _____ **Street Address**: _____**Telephone #:** _____

Referred to our office by ☐Self ☐Dentist ☐Physician ☐Internet ☐Friend Name:_____

All past medical/dental history is important for your optimal care. Please take time to be accurate and thorough in answering the following question. Additional 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 all current prescriptions, nonprescription medications & Supplements (Including Osteoporosis Medications)_____

_____

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

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

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**: _____

Parent or Guardian Signature (if minor) _____ **Date**: _____

Dr's initials: _____