

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

Social Security # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Legal Name

Wished to be called \_\_\_\_\_

Responsible Party \_\_\_\_\_  
Name/Relationship

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F

Birth date \_\_\_\_\_ Age \_\_\_\_\_

Married  Widowed  Single

Minor  Separated  Divorced

Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Birth Date \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

How did you hear about our office?  
 \_\_\_\_\_

## 2 INSURANCE INFORMATION

Subscriber's Name \_\_\_\_\_

Subscriber's Birth date \_\_\_\_\_

Subscriber's ID or SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is there any additional dental insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Subscriber's Birth date \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by medical insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Subscriber's Birth date \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I understand that Dr. Stephen E. Burch does not participate with any insurance companies and that reimbursement will come to me directly from the insurance company. I further understand that Dr. Burch is NOT a participating provider of Medicare and that NO claims can be submitted from this office.

The above named dentist may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative

## 3 CONTACT INFORMATION

Home (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Used for Confirming Appointments

Used for Confirming Appointments

### IN CASE OF EMERGENCY

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

**4 DENTAL INTERVIEW Fear, Trust, Time, Money, Urgency DISC**

Date of Last Dental Visit \_\_\_\_\_

Reason for Today's Visit \_\_\_\_\_

Do you want your teeth to last a lifetime?  Yes  No

How healthy would you like us to help you get your mouth?  Ideal  Average  Don't really care

Are you happy with the appearance of your teeth/smile?  Yes  No

What would you change? \_\_\_\_\_

If we mutually decide that you need some dental treatment, how soon would you like to initiate it?

When a condition is not ideal  When a condition is beginning to worsen  When the condition hurts or breaks

Does your mouth function properly?  Yes  No

Are you fearful?  Yes  No Rate your fear level 1-10 \_\_\_\_\_

Reason for the fear?  Needles  Smell  Sound  Fear of Pain  GS  Triaz  Both

Do you know we provide in-office financing?  Yes  No

Did you have any finance concerns?  Yes  No

What are your financial concerns? \_\_\_\_\_

Special time frames? \_\_\_\_\_

*Place a mark on "yes" or "no" to indicate if you have had any of the following:*

- Clenching teeth  Yes  No
- Clicking or popping jaw  Yes  No
- Fingernail biting  Yes  No
- Grinding teeth  Yes  No
- Headaches  Yes  No
- Jaws pain or tiredness  Yes  No
- Lip or cheek biting  Yes  No
- Orthodontic treatment  Yes  No
- Pain around ear  Yes  No
- Sensitivity to biting  Yes  No
- Sensitivity to hot, cold, sweets  Yes  No
- Vertigo  Yes  No
- Limited opening  Yes  No
- Cervical pain  Yes  No

- Ringing in the ears  Yes  No
- Bad breath  Yes  No
- Bleeding gums  Yes  No
- Dry mouth  Yes  No
- Food collection between teeth  Yes  No
- Gums swollen or tender  Yes  No
- Mouth breathing  Yes  No
- Periodontal treatment  Yes  No
- Blisters on lips or mouth  Yes  No
- Burning sensation on tongue  Yes  No
- Chew on one side of mouth  Yes  No
- Loose teeth or broken fillings  Yes  No
- Sores or growths in your mouth  Yes  No
- Loose teeth  Yes  No
- Paresthesia of Fingers(Tingling)  Yes  No
- Difficulty swallowing  Yes  No
- Postural problems  Yes  No
- Bell's Palsy  Yes  No
- Nervousness/ Insomnia  Yes  No
- Facial or Trigeminal Neuralgia  Yes

## 5 HEALTH HISTORY

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Date of last Full Physical \_\_\_\_\_

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
ANEMIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight _____ lbs.	
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Height _____ ft. _____ in	
		Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you use tobacco products?

Yes  No If yes, what and how often, how long \_\_\_\_\_

Do you use antidepressants or sleeping pills?

Yes  No If yes, list name(s) \_\_\_\_\_

Sleep Apnea  Yes  No (C Pap)  Yes  No

Have you had sleep Studies  Yes  No

Do you Snore  Yes  No

Are you on any blood thinners, including aspirin?

Yes mg \_\_\_\_\_  No

Are you currently taking or have you taken any of the following medications?

Alendronate-Fosomax-oral  Yes  No

Clodronate-Ostac, Bonfos-IV and oral  Yes  No

Etidronate-Didronel—IV and oral  Yes  No

Ibandronate-Boniva-oral  Yes  No

Pamidronate-Aredia—IV  Yes  No

Risedronate-Actonel--oral  Yes  No

Tiludronate-Skelid—oral  Yes  No

Zoledronic acid-Zometa—IV  Yes  No

### WOMEN:

Are you pregnant?

Yes  No If yes when is your due date? \_\_\_\_\_

Taking birth control pills?  Yes  No

Are you taking hormones?  Yes  No

### MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Vitamins/Minerals  Herbs

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

### ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____
<input type="checkbox"/> None	_____

## 6 CONSENT AND RELEASES

Please **INITIAL** and **SIGN** below.

\_\_\_\_\_ I hereby authorize Dr. Stephen E. Burch and/or his staff to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care and treatment, and hereby authorize their use for educational purposes in future lectures, and demonstrations by Dr. Burch and/or his staff.

\_\_\_\_\_ I hereby give my permission to have my testimonials and/or photos, slides, and videos utilized by Dr. Burch and/or his staff for professional marketing to help other patients understand the benefits of the services rendered by this office. I further understand I will receive no further financial compensation for the use, at anytime in the future, of my testimonials, photos, slides, or videos by Dr. Burch and his staff.

\_\_\_\_\_ I hereby give a limited duration of health care power of attorney to (name) \_\_\_\_\_ of (address) \_\_\_\_\_ and (phone) \_\_\_\_\_ my (relationship) \_\_\_\_\_ and by so doing, I hereby give my permission and consent for them to make treatment decision(s), including surgery and medication, on my behalf during my sedation visit(s). I hereby ratify and confirm all that my attorney shall do or cause to be done by virtue of this health care power of attorney and the rights and powers granted herein. Upon conclusion of my sedation treatment with Dr. Burch then this health care power of attorney shall be considered revoked.

\_\_\_\_\_ I understand that responsibility for payment for dental services provided by this office for myself or my dependent is solely mine, with full payment due and payable before the time of services rendered. In the event of default in any payment, I promise to pay the legal interest rate on such indebtedness until fully paid together with all collection cost(s) including non-sufficient fund fees, court costs, and reasonable attorney's fees that may be required to effect full collection of this note and any balance due hereunder, whether or not formal litigation is instituted.

\_\_\_\_\_ Pursuant to Virginia Law 32.1-45.1 – Any patient who exposes a health care provider or his employee/agent to body fluid in a manner which may transmit the human immunodeficiency virus(HIV), Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis B and C testing and disclosure of the results to the person exposed. This deemed consent also applies to a health care provider who exposes a patient to body fluid in the above stated manner.

\_\_\_\_\_ You must provide us with **48 business hours** advance notice for any cancellations of any of your appointments in order to avoid the imposition of cancellation fees, which are determined by the length and type of service being rendered at the scheduled visit. Such cancellation fees are **non-refundable**.

\_\_\_\_\_ I have read and understood this entire agreement before signing here below, and I have endorsed this agreement voluntarily, without duress, and of my own free will and choice, and I received a copy of this agreement simultaneously upon my endorsing it.

**\*\*\*\*\*DO NOT SIGN UNLESS YOU'VE READ AND UNDERSTOOD\*\*\*\*\***

Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_