Anne Newman DDS | **Roanoke General Dentist**
212 Highland Ave SW | **Roanoke, Virginia 24016**

PATIENT INFORMATION (Please Print)

CONFIDENTIAL

First Name: _____ MI: ____ Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary phone #: _____ ☐cell ☐home Secondary phone #: _____ ☐cell ☐home

Email Address: _____ SSN: _____ Sex: ☐Female ☐Male

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Employer: _____ Work #: _____ Occupation: _____

How did you hear about our office? _____

Date of Birth: _____/_____/_____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

SPOUSE INFORMATION

First Name: _____ MI: ____ Last Name: _____ Date of Birth: _____/_____/_____

Primary phone #: _____ ☐cell ☐home Secondary phone #: _____ ☐cell ☐home

Employer: _____ Work #: _____ Occupation: _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone #: _____

RESPONSIBLE PARTY (if other than yourself)

First Name: _____ MI: ____ Last Name: _____ Date of Birth: _____/_____/_____

SSN: _____ Relation: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary phone #: _____ ☐cell ☐home Secondary phone #: _____ ☐cell ☐home

PREFERRED PHARMACY

Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: 540-344-6535 • Fax: 540-345-6986 • AnneNewmanDDS.com

PRIMARY DENTAL INSURANCE INFORMATION

Is subscriber the same as patient? ☐Yes ☐No

Subscriber Information:

First Name: _____ MI: ____ Last Name: _____ Date of Birth: _____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____ SSN: _____

Primary phone #: _____ ☐cell ☐home Secondary phone #: _____ ☐cell ☐home

Employer: _____ Work #: _____ Occupation: _____

Work Address:_____ City:_____ State:_____ Zip:_____

Ins. Company: _____ Group #: _____ ID#: _____

Ins. Co. Address:_____ City:_____ State:_____ Zip:_____

Patient Relationship to Subscriber: ☐Child ☐Disable Dependent ☐Husband ☐Self ☐Wife ☐Other

SECONDARY DENTAL INSURANCE INFORMATION

Is subscriber the same as patient? ☐Yes ☐ No

Subscriber Information:

First Name: _____ MI: ____ Last Name: _____ Date of Birth: _____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____ SSN: _____

Primary phone #: _____ ☐cell ☐home Secondary phone #: _____ ☐cell ☐home

Employer: _____ Work #: _____ Occupation: _____

Work Address:_____ City:_____ State:_____ Zip:_____

Ins. Company: _____ Group #: _____ ID#: _____

Ins. Co. Address:_____ City:_____ State:_____ Zip:_____

Patient Relationship to Subscriber: ☐Child ☐Disable Dependent ☐Husband ☐Self ☐Wife ☐Other

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Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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:

X _____ Date: _____

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DENTAL HISTORY AND QUESTIONNAIRE

Date of last dental visit: ☐ Last 6 mos. ☐ 1-3 yrs. ☐ 4+ yrs. ☐ Never

Reason for last visit: _____

Former Dentist: _____ City: _____ State: _____

When was your last cleaning? ☐ Last 6 mos. ☐ 1-3 yrs. ☐ 4+ yrs. ☐ Never

X-rays last taken? ☐ Last 6 mos. ☐ 1-3 yrs. ☐ 4+ yrs. ☐ Never

1. Do you take pre-medication for anything? **YES** / **NO** **If yes,** what kind? _____

2. Are you currently having any dental problems/concerns? **YES** / **NO** **If yes,** please explain: _____

_____

3. Has any dental treatment been recommended to you that has not been completed? **YES** / **NO**

4. Have you ever had a reaction to local anesthetic that contains epinephrine? **YES** / **NO**

PLEASE RATE THE PRESENT CONDITION OF YOUR MOUTH: Poor 1 2 3 4 5 6 7 8 9 10 Excellent

5. Have you ever been treated for gum disease? **YES** / **NO**

6. Do you smoke, chew tobacco, or vape? **YES** / **NO** **If yes,** for how long? _____ How often? _____

7. Are your teeth sensitive to: ☐ Cold ☐ Heat ☐ Pressure ☐ Sweets ☐ Nothing Which teeth? _____

8. How often do you brush your teeth? _____ Do you notice any bleeding? **YES** / **NO**

Brush type: ☐ Manual ☐ Electric Brush head: ☐ Soft ☐ Medium ☐ Hard

9. What do you use between your teeth? ☐ Floss ☐ Pick ☐ Proxabrush ☐ Nothing How often? _____

10. Are you currently wearing dentures? **YES** / **NO** **If yes,** how long have you had them? _____

12. Are you concerned with grinding or clenching your teeth (bruxism)? **YES** / **NO**

13. Are you aware of any possible TMJ problems? **YES** / **NO** **If yes,** please explain: _____

14. Have you ever worn a splint/guard? **YES** / **NO** **If yes,** do you still wear one? **YES** / **NO**

PLEASE RATE THE APPEARANCE OF YOUR SMILE: Poor 1 2 3 4 5 6 7 8 9 10 Excellent

15. Would you like a whiter smile? **YES** / **NO**

16. Would you like straighter teeth? **YES** / **NO**

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17. Have you had your teeth straightened/worn braces? **YES** / **NO** **If yes**, for how long? _____

18. Are you concerned with bad breath? **YES** / **NO**

19. How would you consider your diet to be? ☐ Good ☐ Fair ☐ Poor

20. Do you consume any of the following?

    Coffee: **YES** / **NO** How many cups? _____ How often? _____

    Soda: **YES** / **NO** How many cans/cups/bottles? _____ How often? _____

    Sweets: **YES** / **NO** How often? _____

21. How often do you snack between meals? ☐ Never ☐ Seldom ☐ Often

22. Do you use gum, mints, or cough drops? ☐ Never ☐ Seldom ☐ Often

23. Do you exercise? **YES** / **NO** **If yes,** how often? _____ What do you do? _____

24. How much of a priority is it to keep your natural teeth over your lifetime? ☐ High ☐ Low ☐ Not sure

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PLEASE RATE THE QUALITY OF YOUR SLEEP: Poor 1 2 3 4 5 6 7 8 9 10 Excellent

25. Are you concerned with snoring or sleep apnea? **YES** / **NO**

26. Do you use a CPAP machine? **YES** / **NO**

27. Do you often feel tired/fatigued/sleepy during the day? **YES** / **NO**

28. Has anyone ever observed you stop breathing/choking/gasping during your sleep? **YES** / **NO**

29. Do you have/are you being treated for high blood pressure? **YES** / **NO**

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*How do you feel about visiting our office? _____

*What concerns you most about visiting the dentist? _____

*We know that excessive stress can negatively influence all aspects of your health. What do you feel are the biggest stressors you are facing? _____

*Is there anything else that you would like us to know about, or focus on at your visit? _____

_____

Patient Signature: _____ **Date:** _____

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FINANCIAL POLICY

Thank you for choosing the office of Dr. Anne Newman, DDS for your dental care. Our primary goal is to provide exquisite dental care in a comfortable, relaxed environment. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

****PAYMENT IS DUE IN FULL AT THE TIME SERVICE IS PROVIDED. ****
Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit.

Insurance: We are a non-participating provider. At the end of each visit, we will help you file the claim with your insurance company. Your insurance company will reimburse you, not us, for what they cover. Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment to you within 60 days, we ask that you contact your insurance company to make sure payment is expected. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company - Our office is not a party to that contract. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.

Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

Missed Appointment (s) and Cancellations: Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 24-hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Communications with you: By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. We or our agents may call by telephone regarding your account. You agree that we may make such calls to a mobile telephone or other similar device.

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to me. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable in full to Anne Newman, DDS at the time services are rendered. I authorize the release of any information concerning my (or my child's) health and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

This consent was signed by (PRINT NAME PLEASE): _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected heath information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email, or send a text to you to confirm appointments? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____