Christopher T King, DDS, PC

4605 HAYGOOD ROAD | VIRGINIA BCH VA, 23455 | (757) 464-6228

Patient Registration

PATIENT INFORMATION: Date_____

Last Name:_____First Name:_____MI:____

Prefers to be called by:_____

Address:_____

City:_____State:_____Zip:_____

Primary Phone #_____(home/cell) Secondary # _____(home/cell)

Email Address:_____

Birthdate:_____ Male / Female (circle one) Social Security#_____

Married / Single (circle one) Spouse's Name:_____

Emergency Contact Name:_____Phone #_____

IF THIS APPOINTMENT IS FOR YOUR CHILD/DEPENDANT PLEASE PROVIDE GUARDIAN INFORMATION:

Last Name:_____First Name:_____MI:____

Relationship to Patient:_____Birthdate:_____Social Security #: _____

Address:_____

City:_____State:_____Zip:_____

Primary Phone #_____(home/cell) Secondary # _____(home/cell)

Email Address:_____

DENTAL INSURANCE (PRIMARY CARRIER)	DENTAL INSURANCE (SECONDARY CARRIER)
Insurance Company	Insurance Company
Group No.	Group No.
Employer Name	Employer Name
Insured's Name	Insured's Name
Date of Birth	Date of Birth
Relationship to Patient	Relationship to Patient
Insured's ID #	Insured's ID #
Insured's SSN	Insured's SSN

You were referred to us by:_____

Christopher T King, DDS, PC

4605 HAYGOOD ROAD | VIRGINIA BCH VA, 23455 | (757) 464-6228

Patient Name: _____ **Date of Birth:** _____

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form completely. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you have any dental problems now? Yes No If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get mouth sores?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have you noticed any loose teeth / change in bite?	Yes	No
Does food get caught in your teeth?	Yes	No

Do you:

Clench or grind while awake or asleep?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Snore or have any other sleeping disorders?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

TMJ Questionnaire - Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face) ……	Yes	No
Difficulty opening or closing mouth?	Yes	No
Difficulty chewing on either side?	Yes	No
Headaches, neckaches, shoulder aches?	Yes	No
Sore jaw or teeth, especially in the morning?	Yes	No

Do you feel nervous about having dental treatment? Yes No

Please describe _____

Have you ever had an upsetting dental experience? Yes No

Please describe _____

Have you ever been sedated for dental treatment? Yes No

Please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

Patient Name: _____

1. Physician's Name _____ Phone ( ) _____

Have you had any medical care in the past two years? ..... Yes No

Describe _____

2. Have you taken any medications or drugs in the past two years? ..... Yes No

If yes, please list name and dosage _____

3. Are you currently taking any medication, drugs, pills or herbal remedies including regular doses of aspirin? ..... Yes No

If yes, please list name and dosage _____

_____

4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ..... Yes No

If yes, please list name and dosage _____

5. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ..... Yes No

If yes, please specify _____

6. Have you ever been told to take an antibiotic pre-medication prior to dental treatment? ..... Yes No

❖ Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item:

Heart (surgery, disease, attack).	Yes	No	Ulcers……..	Yes	No	Hepatitis A B C (circle)…….	Yes	No
Chest Pain……..	Yes	No	Diabetes……	Yes	No	AIDS/HIV positive……	Yes	No
Congenital Heart Disease……	Yes	No	Thyroid Problems……..	Yes	No	Hemophilia……	Yes	No
Heart Murmer……	Yes	No	Glaucoma……..	Yes	No	Sickle Cell Disease……...	Yes	No
High/Low Blood Pressure……	Yes	No	Kidney Trouble……..	Yes	No	Liver Disease / Jaundice……..	Yes	No
Mitral Valve Prolapse……	Yes	No	Emphysema……..	Yes	No	Neurological Disorders……	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Hay Fever/Allergies/Hives……..	Yes	No	Epilepsy or Seizures……	Yes	No
Rheumatic Fever……..	Yes	No	Tuberculosis…….....	Yes	No	Fainting or Dizzy Spells……	Yes	No
Cortisone Medication……	Yes	No	Asthma……	Yes	No	Nervous / Anxious……	Yes	No
Swollen Ankles……..	Yes	No	Cancer……	Yes	No	Psychiatric/Psychological Care..	Yes	No
Stroke……..	Yes	No	Chemotherapy……..	Yes	No	Artificial Joints ……..	Yes	No
Diet (Special/Restricted)……..	Yes	No	Radiation Therapy……	Yes	No	Latex Sensitivity……	Yes	No

7. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No

If yes, please list: _____

8. Do you smoke / chew tobacco or use other tobacco products? ..... Yes No

If yes, how much? _____

9. **Women:** Are you pregnant or think you could be pregnant? Yes _____ Months No **Nursing?** Yes No

10. Do you use birth control prescriptions? ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review BP: _____ mmHg R / L Pulse: _____ bpm

Provider Signature _____ Date: _____

Christopher T King, DDS, PC

4605 HAYGOOD ROAD | VIRGINIA BCH VA, 23455 | (757) 464-6228

CONSENT FOR TREATMENT

1. I hereby authorize Dr. King or his designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. King to make a thorough diagnosis of: (print patient's name)_____'s dental needs.

2. Upon such diagnosis, I authorize Dr. King or his designated staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

_____ _____

Patient Signature Date

_____ _____

Parent / Responsible Party's Signature Relationship to Patient

Christopher T King, DDS, PC

4605 HAYGOOD ROAD | VIRGINIA BCH VA, 23455 | (757) 464-6228

Written Financial Agreement

Thank you for choosing Christopher T King, DDS, PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Christopher T. King, DDS, PC requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For larger, more comprehensive treatment plans, a 25% non-refundable deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, you are at all times responsible for payment for services. I understand there is no guarantee of payment from my insurance company.

I have received notification of the privacy practices for Christopher T. King DDS, PC.

A fee of $50 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.

Christopher T King, DDS, PC charges $30 for returned checks.

If any legal action is necessary to collect these fees as outlined above, the undersigned agrees to be responsible for the costs and legal fees of 25% of the unpaid amount owed.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I agree to the terms above and all fees incurred.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval