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 Beach, VA 23455 | (757) 464-6228

Patient Name: _____ **Today's Date:** _____
Last First M.I.

Patient's Preferred Name: _____ **Patient Birthdate:** _____
MM/DD/YY

Patient Address: _____

Please fill out everything front and back to the best of your knowledge. All information is completely **confidential**

DENTAL HISTORY

What brings you in today? _____
When was your last dental cleaning? _____
How often do you brush your teeth? _____ Floss? _____
Date of last dental visit: _____
What was it for? _____
Date of last dental x-rays: _____

PREVIOUS DENTIST INFORMATION:
Dentist/Dental Practice Name: _____
Address: _____ Phone Number: _____

Please circle yes or no to the following questions:

Have you ever been required to take antibiotics prior to dental treatment in the past? If yes, please explain: _____	YES	NO
Are you currently in pain?	YES	NO
Do you have a history of clenching or grinding your teeth?	YES	NO
Do you have any problems with eating or chewing?	YES	NO
Do you have any sensitivity with hot or cold?	YES	NO
Do you have any bleeding when brushing and/or flossing?	YES	NO
Have you ever been diagnosed with gum disease or had deep cleanings in the past?	YES	NO
Have you ever had orthodontic treatment?	YES	NO
Do you drink fluoridated water?	YES	NO
Do you smoke or use other tobacco products?	YES	NO
Do you suffer from dry mouth?	YES	NO
Do you wear a removable partial/full denture?	YES	NO
Do you like your smile?	YES	NO
Do you take or have you ever taken bisphosphonate class medications (examples include but not limited to: Boniva, Fosamax, Actonel, Reclast and Aredia)?	YES	NO
Is there anything about your dental treatment you would like us to know? If yes, please explain: _____	YES	NO

For Dental Staff Only

Comments:

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN INFORMATION:

Physician Name: _____

Address: _____ Phone Number: _____

Are you under the care of a specialist? _____

If yes, please explain why _____

Have you had any surgeries or hospitalizations within the last 2 years? _____

If yes, please explain why _____

Women Only:

Are you currently pregnant, think you may be pregnant, or nursing? _____

If pregnant, how many weeks? _____ Birth Control? _____

Please circle yes or no if you have ever been diagnosed or have a history of any of these conditions:

Allergies (Seasonal)	YES	NO		Fever Blisters/Cold Sores	YES	NO
Angina Pectoris	YES	NO		Gastrointestinal/GERD/Reflux	YES	NO
Anxiety/Depression	YES	NO		Glaucoma	YES	NO
Arthritis	YES	NO		Heart Attack	YES	NO
Artificial Heart Valve	YES	NO		Heart Murmur	YES	NO
Artificial Joint Replacement	YES	NO		Heart Transplant	YES	NO
Asthma	YES	NO		Hepatitis	YES	NO
Autoimmune Disease	YES	NO		High/Low Blood Pressure (circle one)	YES	NO
Blood Transfusion	YES	NO		HIV/AIDS	YES	NO
Cancer	YES	NO		Kidney Problems	YES	NO
Congenital Heart Disease	YES	NO		Liver Disease	YES	NO
Diabetes Type I or II (circle one)	YES	NO		Mitral Valve Prolapse	YES	NO
Drug Abuse	YES	NO		Osteoporosis	YES	NO
Eating Disorder	YES	NO		Pacemaker	YES	NO
Endocarditis	YES	NO		Stroke	YES	NO
Epilepsy	YES	NO		Other: _____		

Please circle yes or no if you have ever had an allergic reaction to the following:

Antibiotics	YES	NO		Iodine	YES	NO
Aspirin	YES	NO		Sulfa drugs	YES	NO
Acetaminophen	YES	NO		Metals	YES	NO
Codeine or other narcotics	YES	NO		Animals	YES	NO
Local anesthetics	YES	NO		Food	YES	NO
Latex	YES	NO		Other: _____	YES	NO

Please list your current medications (prescribed and over-the-counter):

I certify that I have read and understand that all the information given on this form is accurate and truthful to the best of my knowledge. I understand how important it is to have an honest health history and that the dentist/dental staff treating me are relying on the information provided on this form to treat me. I acknowledge that my questions/concerns have been answered to my satisfaction and I will not hold the doctor or any member of his staff responsible for any action they take or did not take because of errors or omissions I made on this form.

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

For Dental Staff Only

Comments:

BP: _____mmHg Pulse: _____bpm

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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