# 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/cel
Email Address:				
	Male / Female (circle one)			
Married / Single (circle one) S	pouse's Name:			
Emergency Contact Name:		Phone	#	
IF THIS APPOINTMENT IS F	OR YOUR CHILD/DEPENDAN	T PLEASE PROVI	DE GUARDIAN INF	ORMATION:
Last Name:	First Name:_			MI:
Relationship to Patient:	Biri	thdate:	_Social Security #:	
Address:				
City:	State:		_Zip:	
Primary Phone #	(home/cell)	Secondary #		(home/cel
Email Address:				
	EE (PRIMARY CARRIER)		ANCE (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	t	
		Insured's ID #		
Insured's ID #		modrod o 15 m		

## 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 bo	ack to the best o	of your knowledge. All information is comple	tely <b>confident</b>	ial*
	DEN	TAL 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:		<del></del>		
PREVIOUS DENTIST INFORMATION	:			
Dentist/Dental Practice Name:				
		Phone Number:		
, idai ess.		Thore Number:		
Please circle yes or no to the following qu	estions:			
Have you ever been required to take anti	biotics prior to	dental treatment in the past?	YES	NO
Are you currently in pain?			YES	NO
Do you have a history of clenching or grin			YES	NO
Do you have any problems with eating or			YES	NO
Do you have any sensitivity with hot or co			YES	NO
Do you have any bleeding when brushing			YES	NO
Have you ever been diagnosed with gum		deep cleanings in the past?	YES	NO
Have you ever had orthodontic treatmen	t?	Y	YES	NO
Do you drink fluoridated water?			YES	NO
Do you smoke or use other tobacco prod	ucts?		YES	NO
Do you suffer from dry mouth?  Do you wear a removable partial/full den	h		YES	NO NO
Do you like your smile?	ture?		YES	NO
Do you take or have you ever taken bisph	osphonate clas	s modications (avamples include but not	YES	NO
limited to: Boniva, Fosamax, Actonel, Rec			1.20	
Is there anything about your dental treat			YES	NO
If yes, please explain:				
For Dental Staff Only				
Comments:				

### **MEDICAL HISTORY**

Angina Pectoris YES NO Anxiety/Depression YES NO Anxiety/Depression YES NO Arthritis YES NO Arthritis YES NO Arthritis YES NO Arthritis YES NO Artificial Heart Valve YES NO Artificial Joint Replacement YES NO Asthma YES NO Autoimmune Disease YES NO Blood Transfusion YES NO Cancer YES NO Cancer YES NO Congenital Heart Disease YES NO Diabetes Type I or II (circle one) YES NO Drug Abuse YES NO Drug Abuse YES NO Eating Disorder YES NO Endocarditis YES NO Endocarditi	Physician Name: Address:			Phone Number:		
If yes, please explain why  If yes, please explain why  Vomen Only:  re you currently pregnant, think you may be pregnant, or nursing?  If pregnant, how many weeks?  Birth Control?  If pregnant, how many weeks?  If pregnant, how many of these controls?  If pregnant, how many weeks?  If pregnant, how many of these controls?  If pregnant, how many weeks?  If pregnant, how many weeks?  If pregnant, how many weeks?  If pregnant, how many of these controls?  If pregnant, how many of these controls?  If pregnant, how many of these controls?  If prednant, how many of these controls?  If predn						
If yes, please explain why	Are you under the care of a s	pecialist? _				
If yes, please explain why	If yes, please expl	ain why				
If yes, please explain why  Vomen Only:  re you currently pregnant, think you may be pregnant, or nursing?  If pregnant, how many weeks?  Birth Control?  Birt						
Vomen Only: re you currently pregnant, think you may be pregnant, or nursing?  If pregnant, how many weeks?  Birth Control?  B						
If pregnant, how many weeks? Birth Control? Birth Control. Birth C		ain wny				
lease circle yes or no if you have ever been diagnosed or have a history of any of these conditions:  Allergies (Seasonal)  YES NO Gastrointestinal/GERD/Reflux YES NO Galaucoma YES NO Galaucoma YES NO Garrificial Heart Valve YES NO Heart Murmur YES NO Antificial Heart Valve YES NO Autoimmune Disease YES NO Blood Transfusion YES NO Cancer YES NO Congenital Heart Disease YES NO Diabetes Type 1 orl (circle one) YES NO No Pacemaker YES NO Osteoporosis YES NO Pacemaker YES NO Diabetes Type 1 orl (circle one) YES NO No Pacemaker YES NO Osteoporosis YES NO Osteoporosis YES NO Other:    Concertify 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 noportant it is to have an honest health history and that the dentist (dental staff treating and the information provided on this form to or on yea to the total or any member of his staff respor or on yea to the total or any member of his staff respor or or or or yea to the total or history and that the dentist (dental staff treating and the total or any member of his staff respor or or or yea to the total or history and that the dentist (dental staff treating and the highermation provided on this form. or or or or yea to the total or history and that the dentist (dental staff treating and are relying on the information provided on this form to or or yea to the total or history and that the dentist (dental staff treating and are relying on the information provided on this form to or or yea to the total or did not to ke because of errors or omissions I made on this form.    Date:   Date:						
Rease circle yes or no if you have ever been diagnosed or have a history of any of these conditions:  Allergies (Seasonal)  YES  NO  Angian Pectoris  YES  NO  Angian Pectoris  YES  NO  Anciety/Depression  YES  NO  Artificial Joint Replacement  YES  NO  Astrificial Joint Replacement  YES  NO  Heart Murmur  YES  NO  Heart Transplant  YES  NO  Astrima  YES  NO  Heart Murmur  YES  NO  Astrima  YES  NO  Heart Murmur  YES  NO  Heart Murmur  YES  NO  Astrima  YES  NO  Heart Murmur  YES  NO  Heart Murmur  YES  NO  Heart Murmur  YES  NO  Astrima  YES  NO  Heart Murmur  Heart Murmur  YES  NO  Heart Murmur  Heart Murmur  YES  NO  Heart Murmur  Heart Murmur  Heart	re you currently pregnant, think y	you may be pr	egnant, or r	ursing?		
Allergies (Seasonal)	If pregnant, how many wee	eks?		Birth Control?		
Allergies (Seasonal)						
Angian Pectoris	lease circle yes or no if you have	ever been dia	gnosed or l	nave a history of any of these conditions	:	
Anxiety/Depression  YES NO Arthritis  YES NO Arthritis  YES NO Heart Attack  YES NO Artificial Heart Valve  YES NO Artificial Joint Replacement  YES NO Autoimmune Disease  YES NO Autoimmune Disease  YES NO Heart Transplant  YES NO Heart Transplant  YES NO Heart Transplant  YES NO Autoimmune Disease  YES NO High/Low Blood Pressure (circle one)  YES NO Autoimmune Disease  YES NO HIV/AIDS  YES NO Congenital Heart Disease  YES NO Congenital Heart Disease  YES NO Diabetes Type I or III (circle one)  YES NO Diabetes Type I or III (circle one)  YES NO Diabetes Type I or III (circle one)  YES NO Endocarditis  YES NO Diabetes Type I or III (circle one)  YES NO Endocarditis  YES NO Endocarditis  YES NO Other:    Idease circle yes or no if you have ever had an allergic reaction to the following: Antibiotics  YES NO Other:    Idease circle yes or no if you have ever had an allergic reaction to the following: Antibiotics  YES NO Other:    Idease circle yes or no if you have ever had an allergic reaction to the following: Antibiotics  YES NO Other:    Idease circle yes or no if you have ever had an allergic reaction to the following: Antibiotics  YES NO Other:    Idease circle yes or no if you have ever had an allergic reaction to the following: Acetaminophen  YES NO Other:    Idease 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 tree. 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 resport or any action take because of errors or omissions I made on this form.    Idease Ist your current medications (prescribed and over-the-counter):	Allergies (Seasonal)	YES	NO	Fever Blisters/Cold Sores	YES	NC
Arthritis YES NO Artificial Heart Valve YES NO Artificial Joint Replacement YES NO Artificial Joint Replacement YES NO Asthma YES NO Asthma YES NO Heart Transplant YES NO History Blood Pressure (circle one) YES NO Kidney Problems YES NO Kidney Problems YES NO Liver Disease YES NO Disbets Type I or II (circle one) YES NO Mitral Valve Prolapse YES NO Eating Disorder YES NO Stroke YES NO Endocarditis YES NO Stroke YES NO Stroke YES NO Tother:    Concept and the Artificial Joint Transplant YES NO Stroke YES NO Stroke YES NO Tother:    Concept and transplant YES NO Stroke YES NO Stroke YES NO Tother:    Concept and transplant YES NO Stroke YES NO Stroke YES NO Stroke YES NO Tother:    Concept and transplant YES NO Sulfa drugs YES NO Acetaminophen YES NO Metals YES NO Heating YES NO						NO
Artificial Heart Valve			200000000000000000000000000000000000000	NAME OF TAXABLE PARTY O		NC
Artificial Joint Replacement  YES NO Asthma  YES NO Hepatitis  YES NO High/Low Blood Pressure (circle one) High/Low Blood Pressure (circle one) YES NO High/Low Blood Pressure (circle one) YES NO Cancer YES NO High/Low Blood Pressure (circle one) YES NO Cancer YES NO Liver Disease YES NO Diabetes Type I or II (circle one) Y						NC
Asthma  YES NO Autoimmune Disease YES NO Blood Transfusion YES NO Cancer YES NO Cancer YES NO Cangenital Heart Disease YES NO Diabetes Type I or II (circle one) Nitral Valve Prolapse YES NO Diabetes Type I or II (circle one) Nitral Valve Prolapse YES NO Diabetes Type I or II (circle one) Nitral Valve Prolapse YES NO Diabetes Type I or II (circle one) Nitral Valve Prolapse Nitral Valve Prol			According to the Control of the Cont			
Autoimmune Disease  YES NO Blood Transfusion  YES NO Cancer  YES NO Congenital Heart Disease  YES NO Congenital Heart Disease  YES NO Disabetes Type I or II (circle one)  Invertify 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 supportant 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 tree. 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 respor or any action they take or did not take because of errors or omissions I made on this form.  Action Type I or II (circle one)  In II or II						-
Blood Transfusion YES NO Cancer YES NO Cancer YES NO Congenital Heart Disease YES NO Diabetes Type I or II (circle one) YES NO Diabetes Type I or II (circle one) YES NO Diabetes Type I or II (circle one) YES NO Diabetes Type I or II (circle one) YES NO Drug Abuse YES NO Eating Disorder YES NO Endocarditis YES NO Diabetes Type I or II (circle one) Y						NC
Cancer YES NO Congenital Heart Disease YES NO Diabetes Type I or II (circle one) YES NO Drug Abuse YES NO Drug Abuse YES NO Eating Disorder YES NO Endocarditis YES NO Epilepsy YES NO Epilepsy YES NO  Ilease circle yes or no if you have ever had an allergic reaction to the following:  Antibiotics YES NO Aspirin YES NO Aspirin YES NO Acetaminophen YES NO Codeine or other narcotics YES NO Local anesthetics YES NO Lotex YES NO Codeine or other narcotics YES NO Lotex YES NO Codeine or other narcotics YES NO Lotex YES NO Other: YES NO Lotex YES NO Other: YES NO Lotex YES NO Other: YES NO O						NC
Liver Disease   YES   NO   Diabetes Type I or II (circle one)   YES   NO   Osteoporosis   YES						NC
Diabetes Type I or II (circle one)  PYES NO Drug Abuse  YES NO Endocarditis  YES NO Endocarditis  YES NO Epilepsy  YES NO Epilepsy  YES NO  Coteoporosis  YES NO Stroke  YES NO Other:     Codeine or other narcotics   YES NO   Codeine or other narcotics   YES NO   Local anesthetics   YES NO   Latex   YES NO   Codeine or other narcotics   YES NO   Codeine or other narcotics	Congenital Heart Disease					NC
Eating Disorder Endocarditis YES NO Endocarditis YES NO Stroke Stroke YES NO Other:    Continuous of the properties of t		YES	NO		YES	NC
Endocarditis YES NO Other:    Codeine or other narcotics YES NO Other:   Sulfa drugs Y	Drug Abuse	YES	NO	Osteoporosis	YES	NC
Repliepsy  YES NO Other:  Please circle yes or no if you have ever had an allergic reaction to the following:  Antibiotics  YES NO Solfine YES NO Solfia drugs  Acetaminophen YES NO Metals YES NO Metals  Codeine or other narcotics  YES NO Metals  YES NO Animals  YES NO Animals  YES NO Food YES NO Other:  Please list your current medications (prescribed and over-the-counter):  Please list your current medications (prescribed and over-the-counter):  Coertify 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 majoritant 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 trace. 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 resport or any action they take or did not take because of errors or omissions I made on this form.  Date:  Date:  For Dental Staff Only	Eating Disorder	YES	NO	Pacemaker	YES	NO
Please circle yes or no if you have ever had an allergic reaction to the following:  Antibiotics  Aspirin  Aspirin  YES  NO  Acetaminophen  YES  NO  Acetaminophen  YES  NO  Acetaminophen  Arimals  YES  NO  Animals  YES  NO  Animals  YES  NO  Animals  Arimals  Arimals  YES  NO  Animals  Arimals  Arim	Endocarditis	YES	NO	Stroke	YES	NO
Antibiotics YES NO Sulfa drugs YES NO Sulfa drugs YES NO Sulfa drugs YES NO Metals YES NO Metals YES NO Metals YES NO Animals YES NO Animals YES NO Tood nesthetics YES NO Tood Note: YES NO Tother: YES NO TOT	Epilepsy	YES	NO	Other:		
Antibiotics YES NO Aspirin YES NO Sulfa drugs YES NO Acetaminophen YES NO Acetaminophen YES NO Codeine or other narcotics YES NO Local anesthetics YES NO Local anesthetics YES NO Local anesthetics YES NO Local enesthetics YES NO Tode YES NO Tode YES NO Latex YES NO Tode YES NO Tode YES NO Todes Its your current medications (prescribed and over-the-counter):  **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 inportant 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 true. 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 responding 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**						
Antibiotics YES NO Aspirin YES NO Sulfa drugs YES NO Acetaminophen YES NO Acetaminophen YES NO Codeine or other narcotics YES NO Local anesthetics YES NO Local anesthetics YES NO Local anesthetics YES NO Local enesthetics YES NO Tode YES NO Tode YES NO Latex YES NO Tode YES NO Tode YES NO Todes Its your current medications (prescribed and over-the-counter):  **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 inportant 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 true. 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 responding 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**	lease circle ves or no if you have	ever had an a	llergic reac	tion to the following:		
Aspirin YES NO Acetaminophen YES NO Codeine or other narcotics YES NO Local anesthetics YES NO Latex YES NO  Ilease list your current medications (prescribed and over-the-counter):    Continuous current medications (prescribed and over-the-counter):		The second secon	ACCUSATION OF THE PARTY OF THE		YES	NC
Codeine or other narcotics  YES NO Local anesthetics YES NO Other: YES N	Aspirin	YES	NO	Sulfa drugs	YES	NC
Local anesthetics    YES   NO   Other:   YES   NO	Acetaminophen	YES	NO	Metals	YES	NC
Rease list your current medications (prescribed and over-the-counter):    Country   Co	Codeine or other narcotics	YES	NO	Animals	YES	NC
Clease list your current medications (prescribed and over-the-counter):  Coertify 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 inportant 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 true. 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 responder any action they take or did not take because of errors or omissions I made on this form.  Patient/Guardian Signature:  Date:  Date:  For Dental Staff Only	Local anesthetics	YES	NO	Food	YES	NC
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 inportant 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 true. 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 respondency action they take or did not take because of errors or omissions I made on this form.  Patient/Guardian Signature:  Date:  Date:	Latex	YES	NO	Other:	YES	NC
nportant 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 tree. 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 respondence of any action they take or did not take because of errors or omissions I made on this form.  atient/Guardian Signature:	lease list your current medicatio	ns (prescribed	l and over-t	he-counter):		
	mportant it is to have an honest health his ne. I acknowledge that my questions/conco or any action they take or did not take bec Patient/Guardian Signature:	tory and that the erns have been an ause of errors or o	dentist/dental swered to my omissions I mad	staff treating me are relying on the information pro satisfaction and I will not hold the doctor or any me de on this form.  Date	ovided on this form ember of his staff r	n to tre espon
	For Dental Staff Only				-	
	- Commence				National Property (National Prop	
***	P: mmHg	Pı	ilse.	hnm		

## 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 thorou (print patient's name)	igh diagnosis of:'s dental needs.
2.	Upon such diagnosis, I authorize Dr. King or his designated staff to per treatment mutually agreed upon by me and to employ such assistance proper care.	
3.	I agree to the use of anesthetics, sedatives and other medication as ne that using anesthetic agents embodies certain risks. I understand that recital of any possible complications.	-
4.	I give consent to the doctor's or designated staff's use and disclosure of electronic health records that are individually identifiable as mine for the treatment, payment and health care operations. I understand that only information necessary to provide quality care will be used or disclosed outlining the protection of my personal health information is available.	e purpose of carrying out my the minimum amount of
5.	I agree to be responsible for payment of all services rendered on my be understand that payment is due at the time of service unless other arrain the event payments are not received by agreed upon dates, I unders (18% APR) may be added to my account. If required, I also understand may be made.	ngements have been made. stand that a 1.5% late charge
	Patient Signature	Date
	Parent / Responsible Party's Signature	Relationship to Patient