

*Welcome to Virtue Dental Care. This confidential information will help us prepare for your visit.*

If you are an adult (18+), please start here.

Name \_\_\_\_\_

Mr  Mrs  Ms  Rev  Dr Sex  Male  Female

I prefer to be addressed as \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Address \_\_\_\_\_

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

Single  Married  Divorced  Widowed  Separated

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Work # \_\_\_\_\_ Ext \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Where and when is best to reach you? \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Other family members seen by us \_\_\_\_\_

Last dental visit \_\_\_\_\_

Seen by Dr. \_\_\_\_\_ for \_\_\_\_\_

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

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Work # \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

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

Occupation \_\_\_\_\_

If you are a child/minor, please start here.

Name \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Address \_\_\_\_\_

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

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Parents/Responsible Party \_\_\_\_\_

What do you want to accomplish with your appointment today?

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

Why did you leave the office of your previous dentist?

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

Are you having any discomfort or pain?

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

What about your teeth or your smile would you like to change?

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

Would you like to take advantage of sedation dentistry?

Yes  No

Obstacles I see for having excellent dental care for myself...  
(Please check all that apply.)

I see no obstacles

Time away from work or other obligations

Fear of pain or injections

Fear because of past dental experiences

Cost of treatment

Other \_\_\_\_\_

Do any of the above fears keep you from getting dental treatment?  Yes  No

**PLEASE TURN OVER AND  
COMPLETE THE ADDITIONAL  
INFORMATION ON THE BACK.**

My current MEDICAL health is

excellent  good  poor

Are you under the care of a physician?

Yes  No

Physician Name \_\_\_\_\_

Office Address \_\_\_\_\_

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

Office Telephone \_\_\_\_\_

List all medications you take (prescription and over counter):

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

Have you ever been diagnosed or treated for any of the following:

Heart Murmur  Mitral Valve Prolapse  Artificial Joint  
 Heart Surgery  Rheumatic Fever  Artificial Valve  
 None of the above

Does your physician require you to pre-medicate with an antibiotic prior to dental treatment?

Yes  No

Have you ever been diagnosed or treated for the following:

Heart Attack  Pacemaker  High Blood Pressure  
 Cancer  Hepatitis  Kidney Problems  
 HIV/Aids  Chemotherapy  Radiation Treatment  
 Fever Blisters  Shingles  Epilepsy/Seizures  
 Stroke  Glaucoma  Psychiatric Problems  
 Diabetes  Sinus Trouble  Drug/Alcohol Dependence  
 Ulcers  Tuberculosis  Hemophilia/Bleeding  
 Anemia  Colitis  Venereal Disease  
 Arthritis  Asthma  Difficulty Breathing  
 Fainting  Emphysema  None of the above  
 Additional Medical Conditions \_\_\_\_\_

Are you allergic to or have you had difficulty with any of the following substances:

Penicillin  Tetracycline  Latex  
 Aspirin  Codeine  Dental Anesthetic  
 Sulfa  Erythromycin  Mercury  
 Nickel  None of the above  
 Additional Allergies \_\_\_\_\_

## For Women

Are you taking birth control pills?  Yes  No

Are you pregnant?  Yes  No

Are you nursing?  Yes  No

## Dental Insurance Information

### PRIMARY

Insured Name \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

As a courtesy to our valued patients, we will file claims for your primary insurance; we will provide you with all information necessary to file your claim with your secondary insurance. The responsibility of the insurance company is to you and it is your responsibility to see that you are reimbursed properly. Fees for services provided to insured patients are our usual and customary fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule determined solely by your insurance company. The percentage of the fee paid may therefore be different than the percentage you were told by your insurance company or than the percentage listed in your benefit booklet. Dr. Virtue does not participate with any insurance companies in accepting reduced fee. In deciding who they should participate with, the doctor has selected YOU. We will do our best to see that you receive all of the benefits due you.

The information presented on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy which may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss the treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made. In the event of default, I promise to pay interest of the indebtedness, together with and collection costs and attorney fees as may be required to effect collection.

All amounts 30 days past due are assessed 1.5% per month.

Signed \_\_\_\_\_

Date \_\_\_\_\_