



# Midlothian Family Dentistry

14420 Sommerville Ct  
Midlothian, VA 23113  
(804)897-7900

**WELCOME TO OUR PRACTICE.** Our goal is to help you reach and maintain maximum oral health. Please fill out this chart completely. The better we communicate, the better we can care for you.

Today's date: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Child's name \_\_\_\_\_ M or F \_\_\_\_\_ Birth-date: \_\_\_\_-\_\_\_\_-\_\_\_\_  
FIRST M. Last (Nickname)

Home #: \_\_\_\_\_ Home address: \_\_\_\_\_  
Street City State Zip

Mother's Name: \_\_\_\_\_ Email address: \_\_\_\_\_@\_\_\_\_\_  
\_Single \_Married \_Divorced \_Widowed Birth-date \_\_\_\_-\_\_\_\_-\_\_\_\_ SSN #: \_\_\_\_\_ Home #: \_\_\_\_\_

Home address: \_\_\_\_\_  
Street City State Zip

Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext. \_\_\_\_\_ Employer: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Email address: \_\_\_\_\_@\_\_\_\_\_  
\_Single \_Married \_Divorced \_Widowed Birth-date \_\_\_\_-\_\_\_\_-\_\_\_\_ SSN #: \_\_\_\_\_ Home #: \_\_\_\_\_

Home address: \_\_\_\_\_  
Street City State Zip

Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext. \_\_\_\_\_ Employer: \_\_\_\_\_

### In the event of an emergency, is there someone else whom we should contact?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home #: \_\_\_\_\_ Other #: \_\_\_\_\_

**DENTAL INSURANCE:** Policyholder name: \_\_\_\_\_ Birth-date: \_\_\_\_\_

SSN#: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Employer: \_\_\_\_\_

Ins. Co. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_  
Street or PO Box # City State Zip

If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage your program provides. We accept assignment of most insurance companies. This means that you are responsible for your deductible and the portion the insurance does not cover at the time service is provided. *Remember however, you are responsible for the total treatment fee regardless of what we might calculate as your portion, if for any reason the insurance does not honor their commitment to you or us.*

### CONTRACTUAL AGREEMENT:

#### PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW

**I understand all patient portions are due payable at the time services are rendered.**

**I authorize** payment directly to Midlothian Family Dentistry for the benefit otherwise payable to me under the terms of any insurance. I understand I am financially responsible for all charges arising from the treatment of the below-named patient and any insurance payments will be credited to the account.

**In the event** the bank returns any check given in payment on this account unpaid for any reason, a \$30.00 charge will be added to the account balance each time such a check is returned.

**If all charges** are not paid in full within sixty (60) days from the date of service I agree to pay the service charge of 1.8% per month, twenty-one (21%) per annum, interest on the unpaid balance, along with a \$5.00 late charge.

**If this account** is referred to an attorney for collection, I agree to pay all costs of collection, including, but not limited to, an additional thirty-three and one-third of total balance owed for attorney's fees, in addition to all court costs.

**I understand**, in accordance with Section 32.1-45.1 of the Code of Virginia, 1950, as amended, that if the provision health care services to the patient at this office directly exposes any person by or under the direction and control of the health care provider to the patient's body fluids in a manner which may transmit immunodeficiency virus or HIV, then the patient shall be deemed to have consented to testing for infection with HIV and to the release of such tests results to the persons exposed.

**I further understand** that I will be charged a minimum fee of \$50 per one-half (1/2) hour for all missed or cancelled appointments unless forty-eight hour notice is given.

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

R. A. Sorenson & Associate Employee

Medical Information: Physician's name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Current physical health (*circle one*) good fair poor  
 Is the child currently under the care of a physician? \_\_\_\_\_ If yes, explain reason. \_\_\_\_\_  
 Y/N  
 Is the child taking any medications? \_\_\_\_\_ Please list each one. \_\_\_\_\_  
 Y/N

Has the child ever had any of the following medical conditions? (*Please circle Y or N for each*)  
**It is important that you indicate ALL of your child's medical conditions.**

- |                                |                         |                                |
|--------------------------------|-------------------------|--------------------------------|
| Y N Abnormal Bleeding          | Y N Epilepsy/Seizures   | Y N Mitral Valve Prolapse      |
| Y N Alcohol / Drug Abuse       | Y N Fever Blisters      | Y N Psychiatric Problems       |
| Y N Anemia                     | Y N Frequent Headaches  | Y N Rheumatic Fever            |
| Y N Arthritis                  | Y N Glaucoma            | Y N Shingles                   |
| Y N Artificial bones or joints | Y N Heart Murmur        | Y N Sinus Problems             |
| Y N Asthma                     | Y N Heart Trouble       | Y N Thyroid Condition          |
| Y N Blood Transfusion          | Y N Hemophilia          | Y N Tobacco Use ( _____ a day) |
| Y N Cancer                     | Y N Hepatitis           | Y N Tuberculosis (TB)          |
| Y N Colitis                    | Y N High Blood Pressure | Y N Ulcers                     |
| Y N DENTAL ANXIETY             | Y N HIV+/Aids           | Y N Venereal Disease           |
| Y N Diabetes                   | Y N Kidney Problems     | Y N Other                      |
| Y N Emphysema                  | Y N Low Blood Pressure  |                                |

Please describe any conditions indicated above: \_\_\_\_\_

Is the child allergic to any of the following? (*Please circle Y or N for each.*)

- |                        |                  |                  |
|------------------------|------------------|------------------|
| Y N Aspirin            | Y N Erythromycin | Y N Sulfa Drugs  |
| Y N Codeine            | Y N Latex        | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Penicillin   | Y N Other        |

Please list any additional: \_\_\_\_\_

**Dental History:** Why have you brought your child to the dentist today? \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Has your child ever had a serious / difficult problem associated with any previous dental work? YES or NO If yes, please explain: \_\_\_\_\_

Current dental health is? \_\_ Good \_\_ Fair \_\_ Poor

Does the child...? (*Please circle Y/N for each.*) Suck their thumb or finger? Y N Still drink from a bottle? Y N  
 Brush daily? Y N Floss daily? Y N Take fluoride supplements? Y N

**AUTHORIZATION:** I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I authorize the dental team to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*\*\*\*

**OFFICE USE ONLY:**

I verbally reviewed the medical / dental information above with the patient named herein.

Initials \_\_\_\_\_ Date \_\_\_\_\_