JOHN J. DENISON, DDS, PC
Phone: 757.873.9000 | 895 City Center Blvd
Fax: 757.257.3997 | Suite 106
www.drdenison.com | Newport News, VA 23606

MEDICAL HISTORY

Patient Name: _____ **PCP:** _____

Date: _____

Allergies

Acrylics	Y	N
Latex	Y	N
Local anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N

Other:

_____
_____
_____
_____
_____

Current Medications:

_____
_____
_____
_____
_____

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal change	Y	N
Thyroid problems	Y	N

Cardiovascular

Artificial heart valve	Y	N
Coronary artery disease	Y	N
Chest pain/angina	Y	N
Congestive heart failure	Y	N
Heart attack	Y	N
Heart murmur	Y	N
High blood pressure	Y	N
High cholesterol	Y	N
Irregular heartbeat	Y	N
Low blood pressure	Y	N
Mitral valve prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

Ear/Nose/Throat

Change in hearing	Y	N
Change in vision	Y	N
Dysphagia	Y	N
Ear pain	Y	N
Glaucoma	Y	N
Hay fever	Y	N
Nasal obstruction	Y	N
Nose bleeding	Y	N
Sinus problems	Y	N
Tonsillectomy	Y	N
Tinnitus	Y	N

Gastrointestinal

Acid reflux	Y	N
Gerd	Y	N
Soft or special diet	Y	N
Ulcers	Y	N

Genitourinary

Frequent urination	Y	N
Kidney disease	Y	N
Nocturia	Y	N

General

Current weight: _____
Height: _____

Cancer	Y	N

Type: _____
_____

Fatigue	Y	N
General weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/hip replacement	Y	N
Liver problems	Y	N
Recent trauma/injury	Y	N
Rheumatic fever	Y	N
Radiation treatment	Y	N
Weight loss	Y	N
Weight gain	Y	N

Hematological

Bleeding problems	Y	N
Hepatitis	Y	N

Oral

Bleeding gums	Y	N
Dry mouth	Y	N
TMJ	Y	N
Clicking jaw	Y	N
Pain in jaw	Y	N
Difficulty swallowing	Y	N
Difficulty chewing	Y	N
Orthodontics	Y	N
Periodontal disease	Y	N
Teeth clenching	Y	N
Teeth grinding	Y	N
Pain in teeth	Y	N
Wisdom teeth extraction	Y	N
Removable teeth	Y	N
Pre-medicated	Y	N

Musculoskeletal

Back pain	Y	N
Fibromyalgia	Y	N
Joint pain	Y	N

Neurological

Alzheimer's disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory loss	Y	N
Multiple sclerosis	Y	N
Muscle weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/numbness	Y	N
Trigeminal neuralgia	Y	N
Tremor	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical dependency	Y	N
Depression	Y	N
Eating disorder	Y	N
Excessive stress	Y	N
Memory problems	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Chest pressure	Y	N
Congestion	Y	N
Shortness of breath	Y	N
Emphysema	Y	N
Pneumonia	Y	N
Pulmonary embolism	Y	N
Tuberculosis	Y	N

Sleep

Daytime sleepiness	Y	N
Morning headaches	Y	N
Obstructive sleep apnea	Y	N
Do you use a CPAP?	Y	N
Snoring	Y	N

Social History

Tobacco usage	Y	N

Number of packs a day:

Smokeless tobacco	Y	N
Alcoholic beverages	Y	N

Number of drinks a day:_____

Other medical history not listed previously:

_____
_____
_____
_____
_____

Patient Signature: _____

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The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you. Thank you.

First Name _____ Last Name _____

Middle _____ Nickname _____ Salutation _____

Check all that apply: ❑ Patient ❑ Policy Holder ❑ Responsible Party

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Phone Ext _____

Sex: ❑ Male ❑ Female Status: ❑ Married ❑ Single ❑ Minor (under 18 years old))

Birthdate _____ Social Security # _____ Driver License # _____

Can we email you? ❑ Yes ❑ No Email Address: _____ Can we text you? ❑ Yes ❑ No

Whom may we thank for referring you? _____

Person to notify in the case of an emergency _____

Relationship _____ Work # _____ Home # _____

Responsible Party _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____

Employer _____

Birthdate _____ Social Security # _____

If you have given us a Post Office Box for your mailing address, please provide your actual physical address:

Street _____ City _____ State _____

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Insurance Information and Authorization

Primary Insurance Coverage:

Name of Insured _____

Relationship to Patient _____

Insured's Birthdate _____ Social Security # _____

Employer /School _____ Phone _____

Name of Insurance Company _____ Phone _____

Group#/Name _____ ID# _____

Deductible_____ Amount Max Annual Benefit _____

Secondary Insurance Coverage:

Name of Insured _____

Relationship to Patient _____

Insured's Birthdate _____ Social Security # _____

Employer /School _____ Phone _____

Name of Insurance Company _____ Phone _____

Group#/Name _____ ID# _____

Deductible_____ Amount Max Annual Benefit _____

Please Read and Sign:

The payment for services is due on the day services are rendered, unless other means of payment are agreed upon by the undersigned and the office of John J Denison, D.D.S., P.C. I authorize the filing of claims against any insurance in force, and further assign and direct payment to John J Denison, D.D.S., P.C. The undersigned understands that he/she is responsible for payment of any charges not covered by this assignment and that any monies recovered in excess of the patient's indebtedness will be refunded. In the event of default on any payment due I agree to pay all costs of collection as well as any attorney fees and court costs deemed reasonable by the court. I authorize my dental treatment and release of any medical or dental information to process claims for services rendered.

Signature _____ Date_____

Signature of patient over 18 years of age or parent or legal guardian

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No Show and Missed Appointment Policy

When our office schedules your appointment, we are reserving a dedicated chair and time slot just for you. Our policy is that if you must reschedule your appointment, you must provide us with at least 24 hours' notice. This courtesy makes it possible to give your reserved time slot to another patient in need.

There is a charge of $50 per hour scheduled for not showing up for scheduled appointments.

****Repeated cancellations or missed appointments will result in loss of future appointment privileges and possible dismissal from the practice.***

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

_____ I understand that should I fail to attend an appointment, I will be subject to a $50 failed appointment fee per scheduled hour missed, which will be applied to my balance.

I have read the above Appointment Policy and have initialed in order to ensure my understanding of this policy.

Print Name _____

Signature _____ Date_____

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Patient Acknowledgment, Authorization, Financial Obligations, and Consent

AUTHORIZATION FOR TREATMENT

I hereby authorize treatment by Dr. John J. Denison, DDS PC and/or affiliated staff member(s) on behalf of myself. The possibility exists (during treatment) for health care workers to become directly exposed to my blood or bodily fluids. In the event of such exposure, state law requires a sample of my blood to be tested for the presence of infectious diseases.

RELEASE OF INFORMATION

I hereby authorize the release of any and all medical, dental and/or charge information about me necessary to determine benefits or the benefits payable for related services and/or necessary for reimbursement from any third party or governmental agency involved in the payment of my treatment including any and all insurance payers. I also authorize the release of information to any hospital, physician, or medical provider to which I may be referred by Dr. John J. Denison, DDS PC and its providers or those providers I list as currently part of my care team including my PCP. I also authorize the taking and use of photographs which can also be used for instructional, training, or marketing purposes. I understand these photos will become part of my medical records.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized insurance benefits be made on my behalf to Dr. John J. Denison, DDS PC for any services rendered to me. I irrevocably direct and assign payment from any insurance coverage, workers compensation, governmental agency and assignment from proceeds from all settlements, judgments or verdicts in favor of the undersigned from third-party liability claims for injuries treated hereunder, in an amount equal to the full amount of charges (including any attorney's fees, collection agency fees, costs and interest) due hereunder. to be made to Dr. John J. Denison, DDS PC.

GENERAL BILLING PRACTICES AND PAYMENT OBLIGATIONS

Dr. John J. Denison, DDS PC will submit most bills directly to your insurance for payment on your behalf. Our registration personnel will ask you for your insurance information at each visit, and it is your responsibility to ensure that we have your correct information. Doing so will help your insurance claim to be paid quickly. Dr. John J. Denison, DDS PC will notify you if we are unable to submit claims to your insurance company on your behalf. If this is the case, you will be supplied with all required billing information; however, payment will be due in full from you at time of service.

ACKNOWLEDGMENT OF PAYMENT OBLIGATIONS

If you have insurance, your insurance policy is a contract between you and your insurance company. You are responsible to Dr. John J. Denison, DDS PC for any charges not covered by your insurance, including but not limited to co-payments, deductibles, and fees for non-covered services. The patient and the undersigned responsible party are primarily liable for payment of the patient's account. It is the patient's and undersigned responsible party's sole responsibility to timely comply with all requirements and supply all information and documents necessary to obtain payment of benefits by any third party or governmental entity as listed above.

PAST DUE BALANCES AND PROCEDURES FOR COLLECTION

Any balance remaining on the account after any insurance adjustments are made and payments are received will be due in full upon receipt of your account statement. The undersigned agree(s) to pay all charges made by medical providers at their current rate. The obligation of each undersigned is an original. direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. You understand that account balances that remain outstanding for 30 days, shall accrue interest at the rate of 3% per month. If payment is not made, you understand that Dr. John J. Denison, DDS PC may take action to collect its fees. The undersigned agree(s) to pay all costs incurred by or on behalf of Dr. John J. Denison, DDS PC in collecting fees, including reasonable attorney's fees.

ACKNOWLEDGMENTS

I, the patient/guardian, acknowledge that I was offered a Dr. John J. Denison, DDS PC Privacy Policy Acknowledgment/Release, and Patient Financial Policy. and given an opportunity to ask questions about the information provided in those documents. In providing my email address, I authorize Dr. John J. Denison, DDS PC to use my email address for the purpose of communicating health-related information or services. I acknowledge that I may opt out of such communication at any time and my email information will not be shared with any organization outside of Dr. John J. Denison, DDS PC. I consent to the Authorization for Treatment, Release of Information, Assignment of Benefits, General Billing Practices and Payment Obligations, Acknowledgment of Payment Obligations, and Past Due Balances and Procedures for Collection as described above.

I consent to the Authorization for Treatment, Release of Information. Assignment of Benefits, General Billing Practices and Payment Obligations. Acknowledgment of Payment Obligations and Past Due Balances and Procedures for Collection as described above.

Patient Name (Please Print) _____

Signature _____ Date _____

Please list anyone you authorize us to speak with regarding your dental treatment.

_____

_____

_____