# MEDICAL HEALTH HISTORY
## (Confidential)

Patient Name _____ Birthdate _____
Last First Initial

## MEDICAL HISTORY

Primary Care Physician _____

Physician's Phone Number _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

Have you ever had a joint replacement? ☐ Yes ☐ No If yes, give approximate dates _____

Have you taken any medications for osteoporosis? ☐ Yes ☐ No If yes, please list _____

_____

Do you smoke? ☐ Yes ☐ No Chew tobacco? ☐ Yes ☐ No If yes, how much daily _____

_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Cough up Blood | ☐ HIV / AIDS | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Diabetes | ☐ Jaw Pain | ☐ Skin Rash |
| ☐ Artificial Joints | ☐ Emphysema | ☐ Kidney Disease | ☐ Stroke |
| ☐ Asthma | ☐ Epilepsy | ☐ Liver Disease | ☐ Swelling of Feet or Ankles |
| ☐ Back Problems | ☐ Fainting | ☐ Mitral Valve Prolapse | ☐ Thyroid Problems |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Organ Transplant | ☐ Tonsillitis |
| ☐ Cancer | ☐ Headaches | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Radiation Treatment | ☐ Ulcer |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Respiratory Disease | ☐ Venereal Disease |
| ☐ Cortisone Treatments | ☐ Hepatitis | ☐ Rheumatic Fever | |
| ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Scarlet Fever | |

## MEDICATIONS

List medications you are currently taking. Please include over the counter medications and herbal supplements:

Medication _____

_____

_____

Pharmacy Name _____ Location _____

## ALLERGIES

| | | |
|---|---|---|
| ☐ Aspirin | ☐ Local Anesthetic | ☐ Latex _____ |
| ☐ Barbiturates (Sleeping pills) | ☐ Penicillin | ☐ Other _____ |
| ☐ Codeine | ☐ Sulfa | ☐ Other _____ |

## SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

# DENTAL REGISTRATION

(PLEASE PRINT)

DRS. NEIGHBORS, MORETTI AND HEROD
1009 Crowder Drive
Midlothian, VA 23113
Telephone: (804) 794-8745

**Date** _____

## PATIENT INFORMATION

Name _____ (LAST / FIRST / MIDDLE INITIAL) Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

E-mail Address _____

How would you like your appointment confirmed? ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Reason for today's visit: _____

_____

## PRIMARY DENTAL INSURANCE

Person Responsible for Account _____ (LAST NAME / FIRST NAME / MIDDLE INITIAL)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Subscriber # _____

## ADDITIONAL DENTAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____

Subscriber # _____

## ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance. I also agree that if my account becomes delinquent, I will reimburse Drs. Neighbors, Moretti and Herod fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees that are incurred in such collection efforts. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ RESPONSIBLE PARTY SIGNATURE

_____ RELATIONSHIP

_____ DATE