WELCOME

Today's Date: _____ Chart #:_____

Patient Information (Confidential)

Patient Name: _____ Birthdate: _____ Age: _____

SS #: _____ Home #: _____ Cell #: _____

Address: _____ City: _____ Zip: _____

Check appropriate space: ☐ Student ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Dentist: _____ Phone #: _____ Referred By DDS/DR: _____

Physician: _____ Phone #: _____ Address: _____

Employer: _____ Occupation: _____ Business Phone: _____

Business Address: _____ City: _____ State: ___ Zip: _____

In case of emergency, who should we contact? _____ Phone: _____

Please list other family members that have visited our office: _____

Responsible Party *(if other than patient)*

Person Responsible for this Account: _____

Relationship to Patient: _____ Birthdate: _____ Soc. Sec. #: _____

Address: _____ City: _____ State: ____ Zip: _____

Responsible Party Employed By: _____ Business Phone: _____

Business Address: _____ Occupation: _____

Responsible Party's Home #: _____ Cell #: _____

Insurance Information

Name of Medical Insurance Company: _____ Phone #: _____

Policy Holder: _____ Relationship to Patient: _____ Birthdate: _____

ID#/SSN: _____ Group #: _____

Name of Dental Insurance Company: _____ Phone #: _____

Policy Holder: _____ Relationship to Patient: _____ Birthdate: _____

ID#/SSN: _____ Group #: _____

Do you have additional insurance? ____yes ____no If yes, please list below:

Name of Insurance Company: _____ Phone #: _____

Policy Holder: _____ Relationship to Patient: _____ Birthdate: _____

ID#/SSN: _____ Group #: _____

Patients Name: DOB: Chart #:

No.	Medical Questions	Check Answer		Additional Information
1.	Are you in good health?	Yes	No	
2.	Has there been any change in your health since last year?	Yes	No	
3.	My last physical exam was on _____.			
4.	Are you now under the care of a physician?	Yes	No	If so, for what condition?
5.	The name and address of my physician is:			
6.	Have you had any serious illness, operation or hospitalization within the past 5 years?	Yes	No	
7.	Are you taking any medicine(s) including non-prescription?	Yes	No	**LIST MEDICATIONS BELOW**
8.	Do you have or have you had any of the following diseases or problems?	Yes	No	
	a. Damaged heart valves, artificial valves or murmur	Yes	No	
	b. Rheumatic Heart Disease	Yes	No	
	c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition:	Yes	No	
	1. Chest pain on exertion?	Yes	No	
	2. Shortness of breath after mild exercise?	Yes	No	
	3. Do your ankles swell?	Yes	No	
	d. Allergy/Sinus trouble	Yes	No	
	e. Artificial joint replacements	Yes	No	
	f. Asthma or hay fever	Yes	No	
	g. Fainting spells or seizures	Yes	No	
	h. Diabetes	Yes	No	
	i. Hepatitis, jaundice or liver disease	Yes	No	
	j. Frequent or recurring mouth sores	Yes	No	
	k. Thyroid problems	Yes	No	
	l. Respiratory problems, emphysema, bronchitis, etc.	Yes	No	
	m. Arthritis or painful, swollen joints	Yes	No	
	n. Stomach ulcer or hyperacidity	Yes	No	
	o. Kidney trouble	Yes	No	
	p. Tuberculosis	Yes	No	
	q. Persistent cough or cough that produces blood	Yes	No	
	r. Persistent swollen neck glands	Yes	No	
	s. Low blood pressure	Yes	No	
	t. Epilepsy or neurological disorder	Yes	No	
	u. Problems with mental health	Yes	No	
	v. Cancer	Yes	No	
	w. Problems of the immune system	Yes	No	
9.	Have you had abnormal bleeding?	Yes	No	
	a. Have you ever required a blood transfusion?	Yes	No	
10.	Do you have any blood disorder such as anemia?	Yes	No	
11.	Have you ever had treatment for a tumor or growth?	Yes	No	
12.	Are you allergic or have you had a reaction to:			
	a. Local anesthetics	Yes	No	
	b. Penicillin or antibiotics	Yes	No	
	c. Sulfa drugs	Yes	No	
	d. Barbiturates or sleeping pills	Yes	No	
	e. Aspirin	Yes	No	
	f. Iodine	Yes	No	
	g. Codeine or other narcotics	Yes	No	
	h. Other	Yes	No	
13.	Have you had any serious trouble associated with previous dental treatment?	Yes	No	If so, explain:
14.	Do you have any other condition or disease you think I should know about?	Yes	No	If so, explain:
15.	Are you wearing contact lenses?	Yes	No	
16.	Are you wearing removable dental appliances?	Yes	No	
17.	**WOMEN -** Are you taking birth control pills?	Yes	No	
	Are you pregnant or nursing?	Yes	No	

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my oral surgeon or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____ **Doctor Signature:** _____ **Date:** _____
(Must be 18 years old)

Parent/Guardian: _____ **Date:** _____ **Relationship:** _____

WALTER K. MURPHY, D.D.S.
ORAL & MAXILLOFACIAL SURGERY

Patient Name:_____ **DOB**_____ **Chart #**_____

NOTICE REGARDING HIV TESTING

Virginia Law requires that we inform you of the following:

The patient is hereby informed in accordance with Section 32.1-45.1 of Code of Virginia, 1950, as amended, that if the provision of health care service to the patient at Walter K. Murphy, DDS, P.C. directly exposes any person employed by or under the direction of Walter K. Murphy, DDS or any other health care provider, to the patient's body fluids in a manner which may transmit Human 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 test results to the person(s) exposed. Thus required the collection of a blood sample and will be performed at the expense of Walter K. Murphy, DDS.

I certify that I have read, and fully understand, this consent for testing.

_____

Patient Signature (must be 18 yrs. Old) *Print Name* *Date*

_____

Patient Legal Guardian Signature *Relationship* *Date*

Patient Representatives Acknowledgement of Notification Where Patient is Unable to Sign

I _____ am the above-names patient's _____
Name of Patient Representative *Relationship to Patient*

and on behalf of the patient hereby acknowledge that the patient has been given the foregoing notification concerning Section 32.1-45.1.

_____

Representative Signature *Print Name* *Date*

AUTHORIZATION AGREEMENTS

I hereby authorize insurance payments be made to Dr. Murphy otherwise payable to me. I hereby authorize Dr. Murphy to release any information regarding my medical history, treatment, or benefits payable for this claim.

If my account is more than thirty (30) days overdue, I hereby agree to pay a billing charge of 1.5% on any outstanding balance until paid in full, unless previous financial arrangements have been made. I hereby agree to pay any and all expenses incurred in collection of my overdue account, including all court costs, collection service fees and reasonable attorney's fees.

If applicable, I request that payment of authorized Medicare benefits be made on my behalf to Dr. Murphy for any services furnished me by that provider. I authorize any holder of medical information about me be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____

Responsible Party *Print Name* *Date*

Acknowledgement of Receipt of Notice of Privacy Practices

Walter K. Murphy D.D.S. P.C.

Our Notice of Privacy Practices for Protected Health Information (the Notice) describes how our office may use and disclose your health information and how you can get access to that information. We encourage you to ask our staff if you have any questions about the information contained in the Notice. We reserve the right to modify the terms of the Notice as permitted by law. A paper copy of the current Notice may be obtained in person from our receptionist or by calling our office at (804) 746-1864.

Our office intends to use and disclose your health information as necessary for treatment, payment, and healthcare operations. Except as set forth in the Notice, we will not use or disclose your health information without first obtaining the written consent of you or your personal representative.

I, _____, have been provided with a copy of this office's Notice of Privacy Practices.

Disclosure to Family Members and Friends

I understand that this office may make disclosures to my family and friends related to my health as part of my current healthcare or to obtain payment for those services.

____ I authorize Walter K. Murphy D.D.S. P.C. to disclose my healthcare information to the following individuals: (include name, relationship to patient and birthdate)

1. _____
2. _____
3. _____
4. _____
5. _____

_____ ___/___/___

Patient Signature or Authorized Representative

Or

____ I do not wish to have my healthcare information disclosed to anyone.

_____ ___/___/___

Patient Signature or Authorized Representative