



DENTAL HEALTH ASSOCIATES

Dennis Calvano, D.M.D & Daniel B. La Grua, D.M.D

DENTAL HISTORY

Previous Dentist _____ How Long? _____
 Most recent dental exam _____ Most recent x-rays _____
 Most recent dental treatment _____
 How often do you have your teeth cleaned ? 3 mo ___ 6 mo ___ 12+ mo ___
What is your immediate dental concern?

PLEASE ANSWER YES OR NOT TO THE FOLLOWING :

- | | |
|---|--------|
| 1. Are you unhappy with the appearance of your teeth? | YES NO |
| 2. Have you had any unfavorable dental experience? | YES NO |
| 3. Do you have any dental fears? | YES NO |
| 4. Problems with effectiveness or bad reactions to dental anesthetic? | YES NO |
| 5. Orthodontic treatment (braces)? If yes, when _____ | YES NO |
| 6. Periodontal(gum) treatment? If yes, when _____ | YES NO |
| 7. Bleeding Gums? | YES NO |
| 8. Avoid brushing any part of your mouth? | YES NO |
| 9. Is any part of your mouth sensitive to temperature? | YES NO |
| 10. Any sore teeth? | YES NO |
| 11. A burning sensation in your mouth? | YES NO |
| 12. Difficulty swallowing? | YES NO |
| 13. An unpleasant odor or taste in your mouth? | YES NO |
| 14. Dry mouth, throat and/or eyes? | YES NO |
| 15. Jaw problems (temporomandibular joint)? | YES NO |
| 16. Difficulty opening your mouth widely? | YES NO |
| 17. Stiff neck muscles? | YES NO |
| 18. Awaken with an awareness of your teeth or jaws? | YES NO |
| 19. Tension headaches? | YES NO |
| 20. Clench or grind your teeth? | YES NO |
| 21. Jaw clicking or popping? | YES NO |
| 22. Lost any teeth? | YES NO |
| 23. Do you sweat or tremble a lot during examination? | YES NO |
| 24. Do strange people or places make you afraid? | YES NO |

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

- YES NO Has your present denture been relined? When? _____
 YES NO Is your present denture a problem? Describe _____
 YES NO Satisfied with the appearance? _____
 YES NO Satisfied with the comfort? _____
 YES NO Satisfied with the chewing ability? _____
 When did you receive your first partial or complete denture? _____
 How long have you worn your present denture? _____

Patient Signature

Date

1557 COMMERCE ROAD, SUITE 204, VERONA VIRGINIA 24482

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ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. Calvano/ La Grua for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and services rendered to me or my dependants, whether or not paid by insurance. I authorize the above doctor(s) and /or any provider or supplier of services in this office to release any of my medical or financial information required to secure payment of benefits and to carry out any necessary treatment, payment activities, and healthcare operations. I authorize the use of this signature (at the end of this form) on all insurance submissions.

FINANCIAL POLICY

Payment of fees and co-payments/deductibles are expected at the time of service. In the event that my account must be turned over for outside collection, I agree to pay all costs related to collection, to include any court costs and attorney fees that may accrue, and an office collection fee of \$ 35.00. I understand that any account information necessary for collection will be released to a collection company that may affect my credit report. I also understand that there is a 1.5 % finance charge for any/all balances that I am billed for and a \$35.00 returned check fee for any check returned for insufficient funds.

OFFICE POLICY

Appointments: a minimum charge may be made for missed or cancelled appointments without prior notification of 24 hours. I understand that failure to give a 24 hour notice that I cannot keep a reserved appointment will result in a missed appointment fee of \$ 50.00 and, should this happen three times, will result in dismissal from the practice. Our office reserves the right to refuse appointments for late cancellations as well as failure to attend. PLEASE REMEMBER THAT ONCE AN APPOINTMENT IS MADE, THIS TIME IS RESERVED ESPECIALLY FOR YOU

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations. Your signature also indicates that you have had full opportunity to read and consider our Notice of Privacy Practices, and that you understand that you have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed on that notice. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you and or to continue treating you if you revoke this Consent

I, THE UNDERSIGNED, UNDERSTAND AND AGREE TO THE POLICIES STATED ABOVE. I CERTIFY THAT THE INFORMATION ON THIS FORM IS ACCURATE, TO THE BEST OF MY KNOWLEDGE.

Date

Signature (Guardian if under 18 years of age)