New Patient Form (Date: ____/____/_____)

DENTAL INNOVATIONS OF VIRGINIA
HONEST EXCELLENCE

Patient Information		
Name: Last First MI		Birth Date (mm/dd/yyyy)
Preferred Name	Gender ☐ Male ☐ Female	Social Security Number (xxx-xx-xxxx)
Home Address: Street APT# City State ZIP		
Home Phone (landline, not for text) # ( )	Mobile Phone (to receive text) # ( )	Work Phone # or Other Phone # ( )
Email Address	Preferred Contact (to receive reminder) ☐Home ☐ Mobile ☐ Other	Person or number we SHOULD NOT call or leave a message:
Emergency Contact Name	Relationship to the patient	Phone # ( )
How did you hear about DIVA (Dental Innovations of Virginia)? ☐Friend/Family ☐ Dentist referral ☐ Direct mail ☐Insurance ☐ Website ☐ Others		

Responsible Party Information		
Name: Last First MI		Birth Date (mm/dd/yyyy)
Relationship to the patient	Gender ☐ Male ☐ Female	Social Security Number (xxx-xx-xxxx)
Home Address: Street APT# City State ZIP		
Home Phone # ( )	Cell Phone # ( )	Work Phone # or Other Phone # ( )

Primary Employer and Dental Insurance Information		
Subscriber (Policy Holder) Name: Last	First MI	Subscriber Birth Date (mm/dd/yyyy)
Relationship to the patient	Employer	Social Security Number (xxx-xx-xxxx)
Insurance Company Address: Street City State Zip		
Insurance Subscriber ID #	Group/Policy #	Insurance Company Phone # ( )

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If you have secondary dental insurance, please present your insurance card to the front desk.

Dental History Information		
What is the reason for your visit today?		
Date of most recent dental exam and dental x-rays or dentist visit		
Is there anything about your smile you would like to change? If yes, what would it be?		
Check all that apply: ☐ Had complications from past dental treatment ☐ Had any reactions to local anesthetic ☐ Teeth are sensitive to hot, cold, biting or sweets ☐ Have popping and/or clicking of your jaw joint ☐ Gums bleed when brushing or flossing ☐ Have or had a burning sensation in your mouth ☐ Others (Please describe)	☐ Had trouble getting numb ☐ Have dry mouth ☐ Food gets trapped between any teeth ☐ Clench or grind your teeth ☐ Had an unpleasant taste of odor in your mouth ☐ Snore or wake up frequently during the night	If any of the checked boxes need further explanation, please describe

Authorization and Consent for Treatment
Notice of Privacy Practices explains how the practice may disclose patient's health information. By authorizing this form, I affirm that I reviewed and understand the Notice of Privacy Practices. I acknowledge that the information above and the health information is correct to best of my knowledge. I reviewed and understand DIVA Practice Conditions and Financial policy. I consent to receive dental treatment. Sign: _____ Date: _____ Self/responsible party/guardian

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Patient Health Information			
Allergy (i.e. Penicillin, Codeine, Latex, seasonal or others)			
Antibiotics premedication (due to joint replacement, heart valve surgery, or other conditions) required?			
Do you take any anticoagulation medicines (Aspirin, Coumadin, Plavix, etc)?			
Have you ever tested positive for Hepatitis B, Hepatitis C, Covid-19, or HIV? If so, when?			
Have you taken any osteoporosis (bisphosphonate) pills or injections (Fosamax, Boniva, Reclast, etc)?			
Have you ever had any of the following? Please check all that apply.			
Heart Problems High blood pressure Prosthetic heart valve Heart stent placement Pace maker/defibrillator Heart attack/ MI Angina/ Chest pain Infective endocarditis **Psychiatric Problems** Depression Panic or anxiety disorder	**Breathing Problems** Coughing Shortness of breath Pneumonia Sleep apnea Asthma Tuberculosis COPD **Other** Kidney disease Cancer Radiation or chemotherapy Artificial joints Complications from surgery	**Blood Problems** HIV disease/AIDS Bleeding disorders **Head, Eyes, Ears, Nose, Throat** Headache TMJ popping, pain Sinus problem **Social History** Smoking Marijuana Recreational drug use	**Gastrointestinal Problems** Hepatitis Liver disease GERD/reflux/ulcers **Endocrine Problems** Diabetes Thyroid disorders **Nervous System Problems** Stroke Epilepsy/Seizure Nerve pain **For Women only** Are you pregnant? Are you nursing?
If you checked yes above or have other problems not listed here, please provide details here.			
Please list all your medications (name, dose, purpose). Use additional paper if you need more space.			