Patient Name:____

Are you currently taking any medications? Yes _____ No _____

Please list all medicines taken, dosage, and the condition that they are taken for:

Medications	Dosage	Condition
____________	__________	_____________
____________	__________	_____________
____________	__________	_____________
____________	__________	_____________
____________	__________	_____________
____________	__________	_____________
____________	__________	_____________

Allergies:

____

____

In case of emergency, please contact:

Name:____

Phone:____

Signature__________________ Date______________________

Chart #: __________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ______________________________ Date: __________
Last, First MI (Preferred Name)

Gender:__________ Marital Status:__________ Age(s) of Child(ren)______________________

Social Security______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ____________ Ext: ______ Best time to call: ________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit:______________ Reason for this visit: ______________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ STD
☐ Other:____________
____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ______________________________ Phone: ______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Internet/Website

Name of person referring you to our practice: ______________________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best time to call: ____________

Address: ____
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name______________________________ Occupation: ______________________

Address: ____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

________________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

________________________________ Date: __________ Relationship to Patient: ______________

Signature of guarantor of payment/responsible party

C. Ben Lennon DDS, Inc. (Referred to as CBL throughout this document)

Patient Consent and Financial Responsibility Agreement

As a patient of CBL, I agree to the following:

1. **Dental Treatment Risks:** I acknowledge that all dental treatment involves some risks and that no guarantees can be given regarding the outcome.
2. **Release of Prescription History:** I authorize any dentist treating me on behalf of CBL to request and receive any and all information regarding my medication history including information maintained by the Virginia Prescription Monitoring Program.
3. **HIV Testing Disclosure:** Under Virginia law, if an employee of CBL comes in contact with your blood or body fluids during your care, CBL has the right to require you to have a current HIV and Hepatititis B or C screening. The law also requires that the results of these tests be released to the person who is exposed to your body fluids without your consent.
4. **Financial Responsibility:** I assign any benefits to CBL that I may have for reimbursement for my dental treatment received at CBL which I may be entitled to from any insurance coverage, worker's compensation benefits, and all settlements, judgments and verdicts against any liable third party. If I fail to pay outstanding CBL balance, I understand CBL will have a lien against any such settlement, judgment or verdict equal to the full amount of my CBL bill. I further direct any attorney handling or disbursing such proceeds to withhold and promptly pay to CBL the full amount of any outstanding balance owed by me, the Patient, to CBL for dental services rendered. I also understand and agree to pay a $30 fee incurred for any returned checks.
5. **All payments Due at Time of Service:** While CBL, as a courtesy to patients, will bill most insurance companies; CBL is under no obligation to do so. If your insurance company fails to pay all or part of your bill, you are responsible for all charges. By signing this agreement, I agree to accept full responsibility of all CBL charges. Full payment is required at the time of service; CBL reserves the right to charge interest at a rate of 12% from the time of delinquency on any outstanding balance. In addition to interest, I agree to pay both any reasonable collection agency and/or attorney fees associated with recovering any outstanding balance. I agree this Agreement is an original, direct, independent promise to pay based on the independent credit worthiness of the Patient or Responsible Party, and is not a collateral or contingent promise to pay the debt of another.
6. **Disclosure of Medical Information and Assignment of Benefits:** I authorize CBL to share my dental information and dental records to my insurance company and third party payers. I also assign the benefits payable for dental services to the dentist or organization furnishing the services or authorize such dentist or organization to submit a claim to Medicare or Medicaid for payment.

7. **Patient/Family Conduct:** While in any CBL office, I agree to be respectful and courteous to the CBL Staff, all dental providers and the other patients. I realize the importance of honoring my scheduled appointments and agree to provide, at least, one full business day notice for rescheduling appointments. Failure to keep appointments or rescheduling without adequate notice will result in a $25 charge on my account. Repeated cancellations and/or no-shows will result in dismissal from the practice.
8. **Notice of Privacy Practices:** I am aware of and/or have received CBL's Notice of Privacy Practices form. Upon receiving an inquiry as to the presence or condition of the Patient, CBL may (unless otherwise requested by the Patient, next of kin, or physician) release at its discretion: the name, address, age, sex, nature of injuries, and /or general condition of the Patient. I understand that a separate written consent is required for me and/or the person(s) listed below to receive copies of my written dental records.

However, I hereby give permission to my dentist and office personnel to verbally discuss any and all of my dental condition(s) with the following person(s).

___________________________________ ______________________________________

Print Individual name & phone # Print Individual name & phone #

__________________________________ ______________________________________

Print Individual name & phone # Print Individual name & phone #

BY SIGNING BELOW, I, ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE MEANING AND CONSEQUENCES OF EACH AND EVERY TERM AND PROVISION OF THIS AGREEMENT.

____ __________________________________

Patient Name(s) Date

____

Signature of Patient/Guardian