

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 _____

C. Ben Lennon, DDS

Patient name: _____ Date of Birth _____

Address: _____ Phone Number _____

Any change in your dental insurance _____

Health Information Update

Have you ever had any of the following? Please check those that apply and list medications taken for :

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | Due date: _____ | <input type="checkbox"/> STD |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems | |

• 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.

Signature of patient, parent or guardian Date: _____

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 Hepatitis 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