Blue Ridge Family Dentistry

1931 Commonwealth Dr. Charlottesville,VA 22901
434-296-5250

In order to serve you properly, we need the following information.
All information is strictly confidential (**Please print clearly)** Date:_____

GENERAL

Patient's Name: _____ Sex (M/F)_____ Birth Date: ___/____/___
First Last M.I.

Address: _____ City: _____ State:_____ Zip_____

Home Phone: (_____) _____Work: Number: (_____)_____ Cell Number(____)_____

Soc. Sec. Num. _____-_____-_____ Email: _____Occupation: _____Marital Status_____

Person Responsible for Account-Name: _____
First Last MI

Relationship to Patient:_____ Date of Birth: _____ Soc. Sec. Num ____- ____- ____

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

Home Phone: (____)_____ Work Phone: (_____)_____ Cell Phone(____)_____

DENTAL HISTORY

Chief Complaint/Reason for Visit: _____
When was your last dental visit? _____Last full mouth Xrays?_____Last Preventative Cleaning? _____

DO YOU HAVE OR USE ANY OF THE FOLLOWING?- (Please Check all that apply)

- ❒ Teeth Sensitivity to cold, heat, sweet, and pressure
- ❒ Bleeding Gum? How long? _____
- ❒ Food Impaction
- ❒ Bad Breath
- ❒ Mouth Breathing
- ❒ Cigarettes, Pipe or Cigar Smoking
- ❒ Clenching or Grinding
- ❒ Pain Around Ear
- ❒ Unusual Sounds in Ear while Eating
- ❒ Orthodontic Treatment
- ❒ Periodontal Treatment
- ❒ Partial or Complete Dentures
- ❒ Finger Nail or Cheek Biting
- ❒ Frequency of Brushing _____
- ❒ Dental Flossing _____
- ❒ Water Jet Device
- ❒ Fluoride Supplement
- ❒ Professional Teeth Whiting

Are you happy with your smile? _____Is there anything about your smile that you would like to change? _____

FINANCIAL POLICY

Do You Have A Dental Insurance Plan? ❒ Yes ❒ No Insurance Company Name _____

Group Number: _____ Plan Name: _____ ID# _____

Name of Policy Holder: _____ Birthdate:____/___/____Relationship to Patient: _____

I authorize treatment for myself/my child and I agree to pay for such treatment. I certify that all the information I have provided is current and correct. I authorize Blue Ridge Family Dentistry to apply for dental benefits on my behalf and to release any information necessary to obtain such benefits. I authorize any dental benefits due me to be paid directly to Blue Ridge Family Dentistry. I understand that my dental policy is a contract between the insured and the insurance company and Dr. Solis is not a party to that contract, therefore I am responsible for any fees not covered by my insurance company. I understand that payment is due at time of service. *****PLEASE NOTE***** We only file COBRA plans for United Concordia and Delta. If COBRA payment is denied, payment in full is due immediately.

I agree to pay the finance charge of 1.5% (18% apr or $2.50 minimum) in addition to a late fee of $5.00 per month on my account if it is over 30 days past due. I agree to pay all fees involved with collection of my account, should it become necessary to utilize any outside collection means (including collection agencies and attorney fees). I agree to pay a fee of $35.00 for any check not honored by my bank. I agree to give a minimum of 48 hours notice for any appointment I must reschedule and I understand that Dr. Solis reserves the right to charge a fee of $100/hr. for missed appointments. Fees must be paid before appointments are rescheduled.

Children under 10 years of age are not permitted in the operatory unless they are being treated. All children must be accompanied by an adult in the reception area, as we cannot assume responsibility for their care. Children under age 18 coming to the office without a parent must have a signed consent for treatment and bring payment.

This agreement shall remain in effect until revoked in writing.

Signature of Responsible Party _____ Date: _____

Submit