Edmund E. Mullins, Jr., D.D.S.
6808 Stoneman Road
Richmond, Virginia 23228
(804) 266-4989

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

Patient's Name _____ Birth Date _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Spouse's Name: _____

If legal minor, name of Parent or Guardian _____

Home Address _____
Street City, State, Zip Phone

Your Employer _____ Spouse's Employer _____

Street _____ Street _____

City, State, Zip _____ City, State, Zip _____

Phone _____ Phone _____

Whom may we thank for referring you? _____

Who is your former Dentist? _____ Date of last appointment? _____

Who is your current Physician? _____ Date of last appointment? _____

Your Social Security Number _____

In the event of an Emergency, contact _____
Name Phone

What time of day do you prefer to be seen? _____

Do you want full Dental Care? ❑ Yes ❑ No Explain: _____
(An estimate of treatment charges will be provided.)

Do you want to be called for 6 months Cleaning and Examinations ❑ Yes ❑ No

Reason for First Visit _____

If legal minor, name of responsible Party _____ Relationship _____

Street _____

City, State, Zip _____ Phone _____

Payment of Professional Fees ❑ Prefer to pay each visit ❑ Visa ❑ MasterCard

PLEASE COMPLETE THE FOLLOWING INFORMATION if you want our office to work with your insurance carrier.

Insurance Company Name and Address _____

_____

_____
Name of Insured Effective Date Group Number Contract Number

Insurance Authorization and Assignment and Dental Service Contract (Please read and sign)

I hereby authorize Edmund E. Mullins, Jr., D.D.S. to furnish information to insurance carriers concerning my treatment, and I hereby assign to Edmund E. Mullins, Jr., D.D.S. all payments for dental services rendered to myself and/or my dependents). It is my responsibility to be aware of the provisions and limitations of my dental insurance policy.

I understand that I am financially responsible for all charges arising for the treatment of myself and/or the above named patient. I agree to pay a FINANCE CHARGE of 1 1/2% per month on balances over sixty (60) days past due, which is an ANNUAL INTEREST RATE OF 18%. If this contract is referred to an attorney for collection, I agree to pay 33 1/3% attorney's fee and all court costs.

Date: _____ Signed: _____

Have you ever had to take any premedication for dental treatment? _____

Are you having any dental problems that require immediate attention? _____

Have you been under a physician's care during the past 2 years? _____ For? _____

Have you ever had major surgery? _____

If female: Are you taking hormones or birth control? _____ Are you pregnant or nursing? _____

Have you ever had a blood test for hepatitis? _____ Were you vaccinated? _____

Have you had canker or cold sores on your lips, tongue, gums or body? _____

Are you taking or have you taken any prescription drugs during the past year? _____ For? _____

Are you allergic to: Penicillin Codeine Local Anesthetics Other _____

Do any of the following cause tooth discomfort? Hot? Cold? Sweets? Chewing?

How often do you brush your teeth? _____ Floss? _____ Water Jet? _____

Do your gums bleed while cleaning? _____

Do your gums ever feel tender or swollen? _____

Have you had periodontal treatment? _____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____ Click or pop? _____

Do you have frequent headaches? _____ Earaches? _____

Have you ever had orthodontic treatment? _____

Do you have any loose teeth? _____ Cracked or broken teeth? _____

Do you have any noticeable wear on your teeth? _____ Food traps? _____

Do you have any missing teeth? _____ Have they been replaced?

If so, how? Fixed ridge Removable partial Full denture Dental implant

Are you comfortable with the replacement? Please describe _____

How do you feel about the appearance of your smile? _____

Please add anything you think is important.

* Have you had or do you now have:

- ❑ Abnormal Blood Pressure
- ❑ AIDS
- ❑ Allergies
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Congenital Heart Lesions
- ❑ Diabetes
- ❑ Drug Dependency
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ Herpes
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Organ Transplant
- ❑ Pacemaker
- ❑ Polio
- ❑ Prolonged Bleeding
- ❑ Prolonged Cough
- ❑ Psychiatric Treatment
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Sickle Cell Anemia
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal Disease
- ❑