**Gregory T. Harvey, D.M.D.**
101 S. Colorado Street • Salem, Virginia 24153

# *Patient Information*

Date _____

Patient's Name _____
Last First Middle Nickname

Single _____ Divorced _____
Married _____ Separated _____
Widowed _____

Male _____ Female _____ Age _____ Birthdate _____ S.S.# _____

Name of Spouse/Parent(s) _____

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Best time to call _____

Employer _____ Occupation _____

Spouse's Name _____ Birthdate _____
Last First Middle

Home Phone _____ Work Phone _____ S.S.# _____

Employer _____ Occupation _____ No. _____

To the best of my knowledge all the preceding answers are true and correct. I will inform your office of any changes at the next appointment.

## *Financial Policies*

1. I understand that I am responsible for payment of all products and services provided to me or my dependents listed blow by Dr. Harvey;s Office on the day of service.

2. I understand I will be charged a $50 fee for any broken appointment without 24 hour notice after the first broken appointment.

3. I understand that consistently broken appointments will require a credit card reservation in order to secure my next appointment.

4. I understand I will be charged a $25 processing fee for returned checks.

5. I understand if my account is not paid within 90 days of treatment it will be turned over to a collection agency or the office attorney and I will be responsible for all collection fees and court costs associated with my delinquent account.

6. I hereby authorize the release of my health care information to my insurance company for the purpose of obtaining payment for services and determing insurance benefits of the benefits payable for related services.

_____ _____
Signature Date

List Dependents

_____

_____

_____

# *Medical History* *Date:* _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

PATIENT NAME _____ Birthdate _____
HOME PHONE _____ WORK PHONE _____ CELL PHONE _____
EMERGENCY CONTACT _____ PHONE NUMBER _____
NAME(S) OF PHYSICIAN _____
PHONE NUMBER _____ NATURE OF CARE _____

## DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Chest Pains | ☐ Frequent Headaches | ☐ Irregular Heartbeat | ☐ Scarlet Fever |
| ☐ Alzheimer's Disease | ☐ Cold Sores/Fever Blisters | ☐ Genital Herpes | ☐ Kidney Problems | ☐ Shingles |
| ☐ Anaphylaxis | ☐ Congenital Heart Disorder | ☐ Glaucoma | ☐ Leukemia | ☐ Sickle Cell Disease |
| ☐ Anemia | ☐ Convulsions | ☐ Hay Fever | ☐ Liver Disease | ☐ Sinus Trouble |
| ☐ Angina | ☐ Cortisone Medicine | ☐ Heart Attack/Failure | ☐ Low Blood Pressure | ☐ Spina Bifida |
| ☐ Arthritis/Gout | ☐ Diabetes | ☐ Heart Murmur | ☐ Lung Disease | ☐ Stomach/Intestinal Disease |
| ☐ Artificial Heart Valve | ☐ Drug Addiction | ☐ Heart Pacemaker | ☐ Mitral Valve Prolapse | ☐ Stroke |
| ☐ Artificial Joint | ☐ Easily Winded | ☐ Heart Trouble/Disease | ☐ Pain in Jaw Joints | ☐ Swelling of Limbs |
| ☐ Asthma | ☐ Emphysema | ☐ Hemophilia | ☐ Parathyroid Disease | ☐ Thyroid Disease |
| ☐ Blood Disease | ☐ Epilepsy or Seizures | ☐ Hepatitis A | ☐ Psychiatric Care | ☐ Tonsilitis |
| ☐ Blood Transfusion | ☐ Excessive Bleeding | ☐ Hepatitis B or C | ☐ Radiation Treatments | ☐ Tuberculosis |
| ☐ Breathing Problem | ☐ Excessive Thirst | ☐ Herpes | ☐ Recent Weight Loss | ☐ Tumors or Growths |
| ☐ Bruise Easily | ☐ Fainting Spells/Dizziness | ☐ High Blood Pressure | ☐ Renal Dialysis | ☐ Ulcers |
| ☐ Cancer | ☐ Frequent Cough | ☐ Hives or Rash | ☐ Rheumatic Fever | ☐ Venereal Disease |
| ☐ Chemotherapy | ☐ Frequent Diarrhea | ☐ Hypoglycemia | ☐ Rheumatism | ☐ Yellow Jaundice |

## Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Have you ever had any serious illness not listed above? ☐ yes ☐ no If yes, please explain _____

Do you require antibiotics before dental work is performed? ☐ yes ☐ no If yes, please explain _____

Have you ever been hospitalized or had a major operation? ☐ yes ☐ no If yes, please explain _____

Are you taking any medications, pills or drugs? ☐ yes ☐ no If yes, please list

_____

_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

# *Dental Questionnaire*

Last First Middle Nickname Date

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? ☐ Yes ☐ No
2. Have you ever had any serious trouble associated with previous dentistry? ☐ Yes ☐ No
3. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
4. Date of last dental visit? _____ Previous Dentist _____
5. Have you ever been treated for periodontal disease (gums, pyorrhea, trench mouth)? ☐ Yes ☐ No
6. How often do you brush? _____ Brush is: ☐ Soft ☐ Medium ☐ Hard
7. Do you have or have you ever had any of the following?

| MOUTH | | | TEETH | | | |
|---|---|---|---|---|---|---|
| Bleeding, sore gums | ☐ Yes | ☐ No | Loose Teeth | ☐ Yes | ☐ No | |
| Unpleasant taste/bad breath | ☐ Yes | ☐ No | Sensitive to hot | ☐ Yes | ☐ No | |
| Burning tongue/lips | ☐ Yes | ☐ No | Sensitive to cold | ☐ Yes | ☐ No | |
| Frequent blisters, lips/mouth | ☐ Yes | ☐ No | Sensitive to sweets | ☐ Yes | ☐ No | |
| Swelling/lumps in mouth | ☐ Yes | ☐ No | Sensitive to biting | ☐ Yes | ☐ No | |
| Ortho treatments (braces) | ☐ Yes | ☐ No | Food Impaction | ☐ Yes | ☐ No | |
| Biting cheeks/lips | ☐ Yes | ☐ No | Clenching/grinding | ☐ Yes | ☐ No | |
| Clicking/popping joint | ☐ Yes | ☐ No | when? | ☐ Night | ☐ Day | ☐ Both |
| Difficult opening or closing jaw | ☐ Yes | ☐ No | Shifting in bite | ☐ Yes | ☐ No | |
| | | | Change in bite | ☐ Yes | ☐ No | |

8. Do you use the following?

| | | | | | |
|---|---|---|---|---|---|
| Brush | ☐ Yes | ☐ No | Dental Floss | ☐ Yes | ☐ No |
| Fluoride Rinse | ☐ Yes | ☐ No | Other _____ | | |

These are the things that are important to me about my dental health: _____

_____

_____

What do you fear most about dental care? _____

_____

Circle One:

1. My Mouth Is:
   a) very comfortable
   b) moderately comfortable
   c) uncomfortable
2. I
   a) think the appearance of my mouth is excellent
   b) am satisfied with appearance of my mouth
   c) am dissatisfied with the appearance of my mouth
3. I
   a) will do anything to keep my natural teeth
   b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them.
4. I
   a) have set goals for my oral health with a previous dentist
   b) want to set goals concerning my dental health
5. I
   a) have always done the best that was recommended for my dental health
   b) have not done what dentists have recommended to me
   c) rarely go, and don't care much about having any dental work completed
6. I
   a) have put dentistry for myself and family high on my priority list
   b) put dentistry for myself and my family low on my priority list
   c) Dentistry is on my list, but it's hard to find
7. I think my present state of dental health is
   a) Excellent
   b) Good
   c) Poor

What are some questions about dentistry and oral health that you have never had adequately answered? _____

_____

_____