Williamsburg Periodontics & dental implants

Fernando Mogrovejo, DDS, MS

Medical History

Name_____Date of Birth _____Today's Date_____

Name of General Dentist_____ Phone_____

Name of Physician_____ Phone_____

Have you seen a physician for a medical condition in the last 6 months?_____ If so, when and why?_____

Have you had an operation, illness or been hospitalized in the last five years?_____ If so, when and why?_____

Have you ever had oral or I.V. bisphosphonate therapy (Actonel, Boniva, Fosamax, Skelid, Didronel, Aredia, Zometa, Bonefos, Prolia, etc.)? _____If so, when and for how long was this treatment?_____

_____

Have you ever been instructed to premedicate with antibiotics prior to dental treatment for any condition such as a heart murmur, artificial joints, Rheumatic Fever, Etc.? _____

Please list all prescription and over the counter medications you are taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Cardio Vascular

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Angina/Chest Pain
- ☐ Damaged Heart Valves
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Congenital Heart Defect
- ☐ Irregular Heart Beat
- ☐ Pacemaker
- ☐ Heart Surgery
- ☐ Other_____

Skin/Musculoskeletal

- ☐ Arthritis
- ☐ Back or Neck Problem
- ☐ Artificial Joint, if so when and what joint_____

Nerves/Sensory

- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizziness
- ☐ Nervousness
- ☐ Numbness/Tingling

Respiratory

- ☐ Bronchitis/Chronic Cough
- ☐ Sinus Problems
- ☐ Tuberculosis(TB)
- ☐ Asthma

Endocrine

- ☐ Diabetes
- ☐ Thyroid Disease

Hematologic

- ☐ Anemia
- ☐ Prolonged Bleeding
- ☐ Take Blood Thinners
- ☐ HIV/AIDS Positive
- ☐ Stroke

Gastrointestinal

- ☐ Gastric Reflux
- ☐ Gastric Bypass Surgery
- ☐ Stomach Ulcers
- ☐ Liver Disease
- ☐ Hepatitis

Urinary

- ☐ Kidney Problems

Other Conditions

- ☐ Mental Health Issues
- ☐ Eye Disease/Tumors
- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ Excessive Snoring
- ☐ Cortisone Treatment
- ☐ Cancer/Tumors
- ☐ Radiation/Chemotherapy
- ☐ Tobacco Use

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other_____

Please list any other medical conditions or concerns not mentioned above that the Dr. should be aware of

_____

_____

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Patient Registration Form

PATIENT INFORMATION

Last Name_____ First Name_____ Middle Initial_____

Sex: Male □ Female □ Date of Birth_____ SS#_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ Employer_____

Emergency Contact_____ Phone _____

RESPONSIBLE PARTY (if different from the patient)

Last Name_____ First Name_____ Middle Initial_____

Address_____ City_____ State_____ Zip_____

SS#_____ Date of Birth_____ Relationship to Patient_____

Home Phone_____ Cell Phone_____ Work Phone_____

PRIMARY INSURANCE INFORMATION (Dental Insurance Only)

Subscriber Name_____ Relationship to Patient_____

Date of Birth_____ SS#_____ Sex: Male □ Female □

Insurance Co._____ Policy#_____ Group#_____

Claim Address_____Phone_____

Name of Employer_____

SECONDARY INSURANCE INFORMATION (Dental Insurance Only)

Subscriber Name_____ Relationship to Patient_____

Date of Birth_____ SS#_____ Sex: Male □ Female □

Insurance Co._____ Policy#_____ Group#_____

Claim Address_____Phone_____

Name of Employer_____

461 McLaws Circle, Suite 1
Williamsburg, VA 23185
757-221-0249

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Financial Policy

Thank you for choosing our office for your dental health care needs. Please read and sign our financial policy before seeing the doctor. We would be happy to answer any questions you may have.

Payment is due at the time of Service. We accept Cash, Check, Visa, Mastercard, Discover Card, American Express, and Care Credit.

Regarding Insurance:

- We are an In-Network provider for Delta Dental Insurance only, however, we will file insurance claims for all insurance companies as a courtesy.
- Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.
- If your insurance carrier is out-of network, all fees are due at time of service. Insurance will be filed and any benefits due will be sent directly to you by your insurance company.
- **Delta Dental Patients** will pay all co-pays, deductibles, and non covered service fees at time of service. If the insurance company does not pay in full within 30 days we ask that you contact the carrier to help speed things up.
- Balances older than 90 days will be billed a finance charge of 1.5% per month and released to a collection agency until paid in full. Returned checks will have an additional processing fee of $30 and any future treatment would require payment by cash or credit card.

Appointments: Once an appointment has been made, please remember that this time has been reserved specifically for you. We reserve the right to charge a fee for any appointment missed or cancelled without 48 hours advanced notice. The missed appointment fee is $75 per scheduled hour with our Dental Hygienist and $100 for each hour scheduled with our Doctor.

I have read the financial policies and agree to abide by the terms outlined in the financial policy agreement. I understand and accept my financial responsibilities.

Signature_____ **Date**_____

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& dental implants

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Authorization for Release of Dental Records and X-rays

I, _____, hereby authorize the doctor and staff of Dr. _____

To release records or knowledge concerning my dental health to:

Williamsburg Periodontics
461 McLaws Circle, Suite 1
Williamsburg, VA 23185

Phone 757-221-0249 Fax 757-221-0250

E-mail images@williamsburgperio.com

I specifically request that you release copies of the following:

_____ All X-rays
_____ All Treatment Notes and Perio Charting
_____ Other:_____

_____ _____
Signature Date

_____
Print patient or guardian name

Williamsburg Periodontics & dental implants

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HIPAA Notice of Privacy Practices
Acknowledgement of Receipt

I hereby acknowledge that I have read and received a copy of this office's HIPPA Notice of Privacy Practices.

Print Name_____ Date_____

Signed_____

I also give Williamsburg Periodontics permission to speak to the following people (if any) regarding my dental health information:

_____

_____

_____

461 McLaws Circle, Suite 1
Williamsburg VA 23185