Smithfield Family Dentistry
Dr. P. Milton Cook, Jr. DDS

WELCOME **and thank you for selecting our dental team!** We will always offer you the most up to date dental care available today. To help us meet your dental needs, please fill out these forms for us. Yes, we hate forms too, but this information is important. Thank you for your cooperation!

PERSONAL INFORMATION

Name _____ Prefer to be called _____

Social Security # _____ Birth Date _____ ( )Male ( )Female ( )Single ( )Married ( )Child

Address _____

City/State/Zip _____

Employer _____ Your Occupation _____

Emergency Contact: Name _____ Phone #_____

Spouse Info: Name _____ DOB _____SS#_____

Employer _____ Work phone # _____

How did you find out about our office? _____

HOW CAN WE CONTACT YOU?

Home Phone _____ Work Phone _____ext. _____

Cellular Phone _____ Pager _____Email _____

Where do you prefer to receive calls? ( )Home ( )Work ( )Cellular ( )Page

DENTAL INSURANCE CARRIER _____

Subscriber's Name _____

Subscriber's Info: Date of Birth _____ Soc Sec # _____

RESPONSIBLE PARTY/GUARANTOR

Name _____ Relation to patient _____

Birth Date _____ Soc Sec # _____ Drivers License # _____

AUTHORIZATION AND RELEASE

I request and authorize Dr. P. Milton Cook, Jr. and/or such persons as he may select, to perform or assist in the performance of any and all reasonable and appropriate dental treatment, and to release any information concerning my dental treatment or my child's to third party payers and/or health practitioners.

Dr. P. Milton Cook, Jr. is not a contracted provider for any insurance company, therefore we are at liberty to discuss all methods of dental treatment for you. We will file dental claims as a courtesy to our patients and assist in making collections from insurance carriers; however, this office does not render services on the assumption that fees will be paid for by an insurance company. Once insurance benefits are received the remaining balance is due in full immediately. ***All dental fees for services performed are the responsibility of the patient and/or guarantor and are to be paid within 30 days from date of service.***

( ) I have received a **Notice of Privacy Practices** from the office of Dr. P. Milton Cook, Jr., D.D.S.
( ) I authorize assignment of dental insurance benefits payment to Dr. P. Milton Cook, Jr., D.D.S.

I have read the above terms and agree to their content.

_____ _____
Signature of patient/Responsible Party Date

HEALTH /MEDICAL HISTORY

We understand that you are here for us to help you care for your teeth and gums. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems. This questionnaire will become a part of your dental record and is considered "Confidential."

Are you currently under the care of a physician, physical therapist, and/or chiropractor? (circle) Yes No
If Yes, please explain _____
Date of last physical examination _____/_____/_____
Reason for last visit? _____
Physician' Name _____ Phone #_____

What medications are you currently taking (include over the counter, vitamins, and herbal supplements)?
_____ _____ _____
_____ _____ _____

Have you ever had an allergic reaction? To: (circle & identify) Medication _____
Food_____ Latex Products _____ Other _____

Have you ever been told to pre-medicate with an antibiotic prior to EVERY dental treatment? (circle) Yes No
In the past, have you ever had artificial joints or a heart valve replaced? (circle) Yes No When? _____

Have you ever been treated for or suffered from: (circle all that apply)

Blood Pressure: High or Low	Heart Disease	Heart Valve	Heart Murmur	Stroke
Bleeding/Clotting Disease	High Cholesterol	Diabetes	Depression	Rheumatic Fever
Hepatitis	HIV/Aids	Fibromyalgia	Tuberculosis	Seasonal Allergies
Sinus Problems	Bronchitis	Snoring	Asthma	Back Problems
Dizziness	Dry Mouth	Trouble breathing normally through your nose		

Other:_____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? (circle) Yes No
If Yes, please explain: _____Date:_____

Has there been any change in your health in the past 2 years? (circle) Yes No
If Yes, please explain: _____

Do you now or have you ever used tobacco? (circle) Yes No
If you currently use tobacco, are you interested in quitting? (circle) Yes No

How many alcoholic drinks do you consume a week? _____

For women: Are you pregnant or do you think you may be pregnant? (circle) Yes No

DENTAL CONCERNS

Reason for today's visit: (circle) Examination/Cleaning Pain/Swelling Broken Tooth/Filling

If other than a cleaning, have you previously been treated for this problem or concern? (circle) Yes No
If Yes, please explain: _____
_____
How long has this been a problem or concern? _____

TELL US ABOUT YOUR LAST DENTAL APPOINTMENT……..

When was your last dental exam & cleaning? _____
Was the treatment there comfortable? (circle) Yes No
If no, please explain: _____
_____

Was the staff there friendly? (circle) Yes No
Were the fees explained before your appointments with your previous dentist? (circle) Yes No
Anything we have not thought of? _____

WHAT ARE YOUR FEELINGS ABOUT YOUR …….

FRONT TEETH
Are you happy with their color? (circle) Yes No
Are you happy with their length? (circle) Yes No
Are they crowded or crooked? (circle) Yes No *Are braces an option? (circle) Yes No
Are you happy with their overall appearance? (circle) Yes No
Anything about them you would change? _____

BACK TEETH
Are they sensitive to hot or cold foods? (circle) Yes No
Do they trap food when you eat? (circle) Yes No
Anything about them you would change? _____

GUMS
Do they ever bleed? (circle) Yes No *Are you seeing a periodontist? (circle) Yes No
Are they sensitive? (circle) Yes No If yes, Who? _____
Do you frequently have bad breath? (circle) Yes No
Anything about them you would change? _____

MISSING TEETH
Do you have any missing teeth? (circle) Yes No
Are you wearing a replacement? (circle) Yes No
Is your denture or partial comfortable? (circle) Yes No
If No, please explain: _____
Anything you would change? _____

SMITHFIELD FAMILY DENTISTRY
NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT

Our *Notice of Privacy Practices* provides information about how we may use and disclose medical and dental information about you. As provided in our notice, the terms of our notice may change. If we change our *NOTICE*, you may obtain a revised copy.

I, _____, have read the **Smithfield Family Dentistry** *Notice of Privacy Practices*.

I understand that I may ask questions to **Smithfield Family Dentistry** staff if I do not understand any information contained in the *Notice of Privacy Practices.*

Smithfield Family Dentistry has the right to disclose relevant health and dental information to my family member, other relative, close personal friend, or anyone identified by me including:

Name:	**Relationship to patient:**
_____	_____
_____	_____
_____	_____
_____	_____

Patient's Signature_____Date_____

Authorized Patient Representative_____Date_____

Relationship to Patient_____

DEEMED CONSENT

I understand that, in accordance with Section 32.1-45.1 of the Code of Virginia, 1905, as amended, if a **Smithfield Family Dentistry** healthcare provider is exposed to my blood or other bodily fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider; that the Virginia Department of Health will be notified; and that appropriate counseling shall be provided if the results are positive.

Patient's (or Guardian's) Signature_____Date_____

Witness_____Date_____