VL Dental

825 Plantation Drive, Suite #140 • Richmond, Texas 77406
281-239-7200
www.VLdental.net

Welcome

Thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please complete this form. If you have any questions or need assistance, please ask, and we will be happy to help.

Patient Information

First Name: _____ Last Name: _____ MI: _____

Address: _____

City, State, Zip: _____

Home #: _____ Work #: _____ Cellular #: _____ Text Messages Y / N

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ Preferred Name: _____

Check appropriate box: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Who may we thank for referring you? _____

Responsible Party Information ☐ Same as above

First Name: _____ Last Name: _____ MI: _____

Address: _____

City, State, Zip: _____

Home #: _____ Work #: _____ Cellular #: _____ Text Messages Y / N

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec: _____ Insured Birth Date: _____

Insured Employer: _____ Plan #: _____

Insurance Company: _____ Subscriber ID#: _____

Address: _____

City, State, Zip: _____

Insurance Company Phone #: _____

Authorization for Treatment and Acceptance of Financial Responsibility

We provide comprehensive, quality dental care, but also strive to keep our fees affordable for our patients. By asking for payment at the time services are rendered, we can eliminate the costs associated with billing. Payment can be made by cash, check or credit card.

I have read and understand the above. I authorize and request my insurance company to pay directly to the dentist (unless I file claims myself). I understand that my dental insurance carrier may pay less than the actual bill for services or estimate, and I agree to be responsible for payment of all services rendered on my behalf or for my dependent at the time services are rendered.

_____

Signature of patient or responsible party 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.

Are you under a physicians care now?	☐ Yes ☐ No	If yes, explain:
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes, explain:
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes, explain:
Are you taking any medication, pills, or drugs?	☐ Yes ☐ No	If yes, explain:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	
Are you on a special diet?	☐ Yes ☐ No	If yes, explain:
Do you use tobacco?	☐ Yes ☐ No	What form and how much:
Do you use controlled substances?	☐ Yes ☐ No	If yes, explain:

Women: Are you					
Pregnant/Trying to get Pregnant?	☐ Yes ☐ No	Taking oral contraceptives?	☐ Yes ☐ No	Nursing?	☐ Yes ☐ No

Are you allergic to any of the following?						
☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Metal	☐ Latex	☐ Local anesthetics
☐ Other If yes, explain:						

Do you have, or have you had, any of the following?					
AIDS/HIV Positive	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Pain in Jaw Joint	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Parathyroid	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Heart Pace Maker	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Easily Winded	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Epilepsy or Seizures	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Have you ever had any serious illness not listed above?			☐ Yes ☐ No	Explain:	

Comments: _____

_____

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