

TODAY'S DATE <small>mm/dd/yyyy</small>	CHART #	SOCIAL SECURITY #	MARITAL STATUS
LEGAL NAME (LAST)		FIRST	MIDDLE
DATE OF BIRTH <small>mm/dd/yyyy</small>		SEX <small>M<small>ALE</small> F<small>EMALE</small></small>	EMAIL ADDRESS
ADDRESS		CITY	STATE
ADDRESS		ZIP CODE	HOME # ()
EMPLOYER	ADDRESS	WORK # ()	CELL # ()
RELATIVE (NOT AT SAME ADDRESS)	RELATIVE ADDRESS	PHONE # ()	

ENTER THE NAME AND PHONE NUMBER OF YOUR MEDICAL AND DENTAL PROVIDER(S) WHOM WE MAY THANK FOR YOUR REFERRAL TO COFS. CHECK ALL THAT MAY APPLY.

NAME	PHONE #	NAME	PHONE #
<input type="checkbox"/> GENERAL DENTIST _____		<input type="checkbox"/> MEDICAL DOCTOR _____	
<input type="checkbox"/> ENDODONTIST _____		<input type="checkbox"/> FAMILY/FRIEND _____	
<input type="checkbox"/> ORTHODONTIST _____		<input type="checkbox"/> SELF _____	
<input type="checkbox"/> PROSTHODONTIST _____		<input type="checkbox"/> OTHER, PLEASE EXPLAIN _____	

HAVE YOU OR A FAMILY MEMBER EVER BEEN A PATIENT OF OUR PRACTICE? NO YES NAME: _____

INSURANCE INFORMATION

MEDICAL/MEDICARE COVERAGE

INSURANCE COMPANY NAME	ADDRESS	CITY	STATE	ZIP CODE
SUBSCRIBER NAME	SUBSCRIBER BIRTHDATE <small>mm/dd/yyyy</small>	SUBSCRIBER SOCIAL SECURITY NO.		
SUBSCRIBER ADDRESS		CITY	STATE	ZIP CODE
EMPLOYER NAME	GROUP NUMBER	POLICY NO.	PATIENT'S RELATIONSHIP TO SUBSCRIBER	
DO YOU HAVE SECONDARY INSURANCE? IF SO, WHAT? <input type="radio"/> YES <input type="radio"/> NO				

DENTAL COVERAGE

INSURANCE COMPANY NAME	ADDRESS	CITY	STATE	ZIP CODE
SUBSCRIBER NAME	SUBSCRIBER BIRTHDATE <small>mm/dd/yyyy</small>	SUBSCRIBER SOCIAL SECURITY NO.		
SUBSCRIBER ADDRESS		CITY	STATE	ZIP CODE
EMPLOYER NAME	GROUP NUMBER	POLICY NO.	PATIENT'S RELATIONSHIP TO SUBSCRIBER	
DO YOU HAVE SECONDARY INSURANCE? IF SO, WHAT? <input type="radio"/> YES <input type="radio"/> NO				

FINANCIAL RESPONSIBILITY

PLEASE COMPLETE THE FOLLOWING INFORMATION IF PATIENT IS UNDER 18 OR IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR BILL

RESPONSIBLE PARTY NAME	DOB: <small>mm/dd/yyyy</small>	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	HOME PHONE # ()
ADDRESS	CITY	STATE	ZIP CODE	CELL # ()
EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE
			PHONE #	

Final Authorization and Acknowledgement

The following authorization and acknowledgement must be signed by the patient if over eighteen (18) years of age. It must be signed by the responsible person if the patient is a minor. **Likewise, it must be signed by a legal guardian or other responsible person if the patient is over eighteen (18) years of age and not responsible for his/her own debts.**

This authorization and acknowledgement must be signed prior to treatment being rendered.

- (1) I hereby authorize the release of any information relating to my insurance claims.
- (2) I hereby authorize payment to the doctor of benefits otherwise payable to me, but not to exceed the charges shown.
- (3) I agree to pay for the services rendered and acknowledge that I am legally liable for the services.
- (4) I understand that insurance is being filed as a courtesy for me and that I am responsible for the full bill sixty days from the date insurance is filed.
- (5) I agree to pay all collection agency fees/attorney fees and any filing fees, court costs or other expenses incurred if my account is referred to a collection agency or attorney for collections. Attorney fees are to be assessed at 33.33% of the balance due.

DATED: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATED: _____

SIGNATURE OF INSURED IF OTHER THAN PATIENT

PATIENT NAME _____

DATE _____

CHART # _____

HEALTH HISTORY

1. Reason for visit: _____

2. Was this due to an injury? Yes No When: Date am pm
 How _____ Time : _____
 Where _____

3. Are you now, or have you ever been, under a physician(s) care during the last 5 years (other than for routine physicals, colds, etc.)? Yes No

4. Please list any and all medications you are taking, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals; or prescription medication for weight loss (diet pills): _____

5. Are you taking or have you taken Bisphosphonates (Fosamax, Acetone1, Aredia, Boniva, Zometa, and Didronel) for osteoporosis, chemotherapy for multiple myeloma, etc.? Yes No

6. List any allergies or unfavorable drug reactions: _____

7. Do you have any reason to believe you may be immunosuppressed (from disease, drugs, transplant surgery, etc.)? Yes No
 If yes, please explain: _____

8. Are you taking any medication or have you had any surgery that may have affected your immune system? Yes No
 If yes, please explain: _____

9. Have you experienced chronic fatigue, night sweats, chronic cough or recurrent mouth sores? Yes No
 If yes, please explain: _____

10. Are you currently being treated or have you ever been treated for a TMJ Disorder? Yes No
 If yes, please explain: _____

11. Do you smoke or chew tobacco? Yes No
 If yes, how much? _____

12. Have you ever had surgery? Yes No
 If yes, please explain: _____

13. Have you ever had IV Anesthesia? Yes No
 If yes, did you have any complications (explain): _____

14. Is there any family history of chronic illness or anesthetic complications? Yes No
 If yes, please explain: _____

15. Indicate which of the following you have had, or have at present. Please mark "Yes" or "No" to each item.

- | | | |
|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart (Surgery,Disease,Attack) | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No Yellow Jaundice |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Contact lenses | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No Cold Sores / Fever Blisters |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Transfusion |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Bruise Easily |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis/Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No Latex Sensitivity | <input type="checkbox"/> Yes <input type="checkbox"/> No Neurological Disorders |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cortisone Medicine / Steroid | <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies or Hives | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy or Seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Swollen Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting or Dizzy Spells |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No Nervous / Anxious |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joints (hip,knee,etc) | <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric/Psychological Care |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Tumors | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Ulcers | | |

16. Do you have or have you had any disease, condition, or problem not listed? Yes No
 If yes, please list/explain: _____

17. Is there any other question or issue you would like to discuss with the doctor? Yes No
 If yes, please explain: _____

18. Women Pregnant? Yes No If yes, No. of months: _____ Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

_____ Patient / Guardian Signature	_____ Date	_____ Physician Review	_____ Date
---------------------------------------	---------------	---------------------------	---------------

Acknowledgement of Receipt of Notice of Privacy Practices

Walter K. Murphy D.D.S. P.C.

Our Notice of Privacy Practices for Protected Health Information (the Notice) describes how our office may use and disclose your health information and how you can get access to that information. We encourage you to ask our staff if you have any questions about the information contained in the Notice. We reserve the right to modify the terms of the Notice as permitted by law. A paper copy of the current Notice may be obtained in person from our receptionist or by calling our office at (804) 746-1864.

Our office intends to use and disclose your health information as necessary for treatment, payment, and healthcare operations. Except as set forth in the Notice, we will not use or disclose your health information without first obtaining the written consent of you or your personal representative.

I, _____, have been provided with a copy of this office's Notice of Privacy Practices.

Disclosure to Family Members and Friends

I understand that this office may make disclosures to my family and friends related to my health as part of my current healthcare or to obtain payment for those services.

____ I authorize Walter K. Murphy D.D.S. P.C. to disclose my healthcare information to the following individuals: (include name, relationship to patient and birthdate)

1. _____
2. _____
3. _____
4. _____
5. _____

Or

____ I do not wish to have my healthcare information disclosed to anyone.

Patient Signature or Authorized Representative

____/____/____

**WALTER K. MURPHY, D.D.S.
ORAL & MAXILLOFACIAL SURGERY**

Patient Name: _____ **DOB** _____ **Chart #** _____

NOTICE REGARDING HIV TESTING

Virginia Law requires that we inform you of the following:

The patient is hereby informed in accordance with Section 32.1-45.1 of Code of Virginia, 1950, as amended, that if the provision of health care service to the patient at Walter K. Murphy, DDS, P.C. directly exposes any person employed by or under the direction of Walter K. Murphy, DDS or any other health care provider, to the patient's body fluids in a manner which may transmit Human Immunodeficiency Virus or HIV, then the patient shall be deemed to have consented to testing for infection with HIV and to the release of such test results to the person(s) exposed. Thus required the collection of a blood sample and will be performed at the expense of Walter K. Murphy, DDS.

I certify that I have read, and fully understand, this consent for testing.

Patient Signature (must be 18 yrs. Old) *Print Name* *Date*

Patient Legal Guardian Signature *Relationship* *Date*

Patient Representatives Acknowledgement of Notification Where Patient is Unable to Sign

I _____ am the above-names patient's _____
Name of Patient Representative *Relationship to Patient*

and on behalf of the patient hereby acknowledge that the patient has been given the foregoing notification concerning Section 32.1-45.1.

Representative Signature *Print Name* *Date*

AUTHORIZATION AGREEMENTS

I hereby authorize insurance payments be made to Dr. Murphy otherwise payable to me. I hereby authorize Dr. Murphy to release any information regarding my medical history, treatment, or benefits payable for this claim.

If my account is more than thirty (30) days overdue, I hereby agree to pay a billing charge of 1.5% on any outstanding balance until paid in full, unless previous financial arrangements have been made. I hereby agree to pay any and all expenses incurred in collection of my overdue account, including all court costs, collection service fees and reasonable attorney's fees.

If applicable, I request that payment of authorized Medicare benefits be made on my behalf to Dr. Murphy for any services furnished me by that provider. I authorize any holder of medical information about me be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Responsible Party *Print Name* *Date*