Dr. Jeryl A. Abbott D.D.S

151 LeGordon Drive
Midlothian, VA 23113
(804) 379-9177

WELCOME TO OUR PRACTICE. Our goal is to help you to reach and maintain maximum oral health. Please fill out chart completely. The better we communicate, the better we can care for you.

Today's date:________________________ Whom may we thank for referring you?____________________

Name:____ I prefer to be called:_________________________
Mr. Mrs. Ms. Dr. First M. Last

___Single ___Married ___ Divorced ___Widowed ___Male ___Female Date of Birth ____-____-_______

SS #_____-____-_____ Home # _____-____-_____ Cell # _____-____-_____ Work # _____-____-_____

Home Address _______________________________________ City ______________ State ____ Zip ___________
E-mail Address ____@___________________
Do we see other family members? ____Yes ____No
Names:____________________________ ____________________________ ____________________________
____________________________ ____________________________ ____________________________

Employer: _____________________________________ Occupation: ______________________________________
Address: ____ City ______________ State ____ Zip ____________

Spouse Name: __________________________________ Date of Birth: ____-____-_______ SS # _____-____-_____
Employer: ____ Work # _____-____-_____ Cell # _____-____-_____
In the event of an emergency, is there someone whom we should contact other than your spouse?
Name: ______________________________ Relation: __________________________ Home #: ____-____-______

DENTAL INSURANCE: Policyholder name: ________________________________ Date of Birth: ____-___-_____
SS # _____-____-_____ Relationship to patient: ______________________ Employer: ______________________
Ins. Co. Name: ___________________________ Phone # _____-____-_____ Group # ________________________
Ins. Co. Address: _____________________________________ City _______________ State ____ Zip ___________

If you have dental insurance we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage your program provides. We accept assignment of most insurance companies. This means that you are responsible for your deductible and the portion the insurance does not cover at the time of service is provided. *Remember however, you are responsible for the total treatment fee regardless of what we might calculate as your portion, if for any reason the insurance does not honor their commitment to you or to us.*

CONTRACTUAL AGREEMENT:
PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW
I understand all patient portions are due payable at the time services are rendered.
I authorize payment directly to Dr. Jeryl A. Abbott D.D.S. For the benefit otherwise payable to me under the terms of any insurance. I understand I am financially responsible for all charges arising from the treatment of the below named patient and any insurance payments will be credited to the account. In the event the bank returns any check given in payment on this account unpaid for any reason a $30.00 charge will be added to the account balance each time such a check is returned. If all charges are not paid in full within sixty (60) days from the date of service I agree to pay the service charge of eighteen (18%) per month, twenty one (21%) annual interest on the unpaid balance, along with a $5.00 late charge.
If this account is referred to an attorney for collection, I agree to pay all costs of collection, including, but not limited to, an additional thirty-three and one-third of the total balance owed for attorney's fees, in addition to all court costs. I understand in accordance with section 32.1-45.1 of the code of Virginia 1950 as amended that if the provision health care services to the patient at this office directly exposes any person by or under the direction and control of the health care provider to the patient's body fluids in a manner that may transmit immunodeficiency virus of HIV, then the patient shall be deemed to have consented to testing for infection with HIV and to release of such tests results to the persons exposed. I further understand that I will be charged a minimum fee of $ 25.00 per one half (½) hour for all missed or canceled appointments unless forty eight (48) hour notice is given.

Name:____________________________ Relationship to patient: ___________________________ Date: _______________
Signature: _________________________Witness:___________________________________ Date: ____________________
Dr. Jeryl A. Abbott & Associate Employee

Medical Information: Physician's name: ___________________________________ Phone # _____-____-_____
Date of last visit: ____________________ Current physical health (circle one) Good Fair Poor
Are you currently under the care of a physician? _______ If yes, explain reason ______________________________
Are you taking any medication? ________ Please list each one ____
____

For Women: Are you taking birth control pills? _____ Are you nursing? _____ Are you pregnant? _____ Week # ___

Have you ever had any of the following medical conditions? (Please circle Y or N for each)
It is important that you alert us of ALL your medical conditions.

Y N Abnormal Bleeding	Y N Epilepsy/Seizures	Y N Mitral Valve Prolapse
Y N Alcohol / Drug Abuse	Y N Fever Blisters	Y N Psychiatric Problems
Y N Anemia	Y N Frequent Headaches	Y N Rheumatic Fever
Y N Arthritis	Y N Glaucoma	Y N Shingles
Y N Artificial Bones / Joints	Y N Heart Murmur	Y N Sinus Problems
Y N Asthma	Y N Heart Trouble	Y N Thyroid Condition
Y N Blood Transfusion	Y N Hemophilia	Y N Tobacco Use (_____ a day)
Y N Cancer	Y N Hepatitis	Y N Tuberculosis (TB)
Y N Colitis	Y N High Blood Pressure	Y N Ulcers
Y N Dental Anxiety	Y N HIV + / AIDS	Y N Venereal Disease
Y N Diabetes	Y N Kidney Problems	Y N Other
Y N Emphysema	Y N Low Blood Pressure	

Please describe any conditions indicated above: ____
____
____

Are you allergic to any of the following? (Please Circle **Y** or **N** for each.)

Y N Aspirin	Y N Erythromycin	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Dental History: Why have you come to the dentist today? ____
Are you interested in sedation for dental work? ____
Previous / Present Dentist: __________________________________ Phone # ____-____-_____
Have you requested to have records transferred to us? _______________________________________
Have you ever had a serious / difficult problem associated with any previous dental work? YES or NO If yes, please explain: ____

Your current dental health is? ____ Good ____ Fair ____ Poor Do you like your smile? YES or NO
Your toothbrush bristles are? ____ Hard ____ Medium ____ Soft Do your gums ever bleed? YES or NO
How often do you brush? ______________________________ Do you floss? YES or NO

AUTHORIZATION: I understand the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I authorize the dental team to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment. **Signature:** ______________________________
Date: __________________________________

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OFFICE USE ONLY: I verbally reviewed the medical / dental information above with the patient named herein.
Initials ____________ Date ____________ Midlothian Dentist - Jeryl Abbott DDS