Samuel W. Galstan, D.D.S., M.P.H., M.A.G.D.
C. Sharone Ward, D.D.S.
12290 Iron Bridge Road
Chester, Virginia 23831
(804) 796-1915

# PATIENT REGISTRATION

PLEASE FILL IN THE FOLLOWING REGISTRATION FORM TO HELP US PROVIDE PROFESSIONAL AND ACCURATE TREATMENT. WE FEEL THIS INFORMATION IS IMPORTANT AND ASK THAT YOU ALSO PROVIDE US WITH ANY OTHER INFORMATION YOU FEEL WILL HELP US SERVE YOU BETTER. THANK YOU.

| DATE | LAST NAME | FIRST NAME ☐ MR. ☐ MRS. ☐ MISS ☐ MS. ☐ DR. | M.I. |
|---|---|---|---|

| MAILING ADDRESS | PHYSICAL ADDRESS | CITY | STATE ZIP CODE | HOME PHONE ( ) |
|---|---|---|---|---|

| CELL PHONE ( ) | EMAIL ADDRESS |
|---|---|

| SOC. SEC. NO. | DATE OF BIRTH | SEX | MARITAL STATUS | EMPLOYER | BUSINESS PHONE ( ) |
|---|---|---|---|---|---|

| PREFERRED # TO CALL | FAMILY PHYSICIAN | ALLERGIES | DRUG REACTIONS |
|---|---|---|---|

| SPOUSE/GUARDIAN NAME | SPOUSE/GUARDIAN S.S. NO. | DATE OF BIRTH | SPOUSE/GUARDIAN EMPLOYER | PHONE NO. ( ) |
|---|---|---|---|---|

| SPECIAL INSTRUCTIONS FOR CONFIRMATION OF APPOINTMENT |
|---|

| IN CASE OF EMERGENCY, NOTIFY: (SOMEONE NOT LIVING WITH YOU) | PHONE ( ) | RELATION |
|---|---|---|

## DENTAL INSURANCE ONLY:

| INSURANCE CARRIER # 1 | INSURED (FIRST AND LAST NAME) | STREET | CITY | STATE | ZIP CODE |
|---|---|---|---|---|---|
| POLICY NUMBER | GROUP NUMBER | RELATION TO INSURED | | | |
| INSURANCE CARRIER # 2 | INSURED (FIRST AND LAST NAME) | STREET | CITY | STATE | ZIP CODE |
| POLICY NUMBER | GROUP NUMBER | RELATION TO INSURED | | | |

| PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT | STREET | CITY | STATE | ZIP CODE |
|---|---|---|---|---|

| SOC. SEC. NO. D.O.B. | RELATIONSHIP TO PATIENT | PHONE ( ) | BUSINESS PHONE ( ) |
|---|---|---|---|

| EMPLOYER | STREET | CITY | STATE | ZIP CODE |
|---|---|---|---|---|

## INSURANCE AUTHORIZATION AND ASSIGNMENT: (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE THIS PRACTICE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY TREATMENT AND I HEREBY ASSIGN TO THE DENTIST ALL PAYMENTS FOR DENTAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

X _____ / / _____

SIGNATURE (BENEFICIARY/PARENT OR GUARDIAN) DATE

## GENERAL INFORMATION

| HOW DO YOU FEEL ABOUT YOUR TEETH? |
|---|
| HOW DO YOU FEEL ABOUT YOUR SMILE? |
| WHAT IS THE MAIN PURPOSE FOR THIS VISIT? |

| HOW OFTEN DO YOU BRUSH YOUR TEETH? | DO YOU FLOSS REGULARLY? |
|---|---|

| WHO MAY WE THANK FOR REFERRING YOU? |
|---|

# MEDICAL HEALTH

| GENERAL HEALTH | ARE YOU NOW UNDER A PHYSICIAN'S CARE? | LAST TIME UNDER A PHYSICIAN'S CARE? | FOR WHAT? |
|---|---|---|---|
| ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR | ☐ YES ☐ NO | / / | |

ARE YOU TAKING ANY MEDICATION NOW?

☐ YES ☐ NO (IF YES, LIST)

| PHYSICIAN NAME | PHONE | STREET | CITY | STATE | ZIP CODE |
|---|---|---|---|---|---|
| | ( ) | | | | |

Have you ever been diagnosed or treated for/with

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Stroke | ☐ | ☐ | Latex Allergy | ☐ | ☐ | Endocarditis | ☐ | ☐ | Mental or | | |
| Angina (Chest Pains) | ☐ | ☐ | Penicillin Allergy | ☐ | ☐ | Codeine Allergy | ☐ | ☐ | Physical Handicaps | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Adrenal Insufficiency | ☐ | ☐ | Epinephrine Sensitivity | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ | Congestive Heart Failure | ☐ | ☐ | Cancer | ☐ | ☐ | H.I.V., AIDS or | | |
| Heart Murmur | ☐ | ☐ | Congenital Heart Problems | ☐ | ☐ | Blood Thinners | ☐ | ☐ | Immune Problems | ☐ | ☐ |
| Abnormal Blood | | | Diabetes | ☐ | ☐ | Bleeding Disorders | ☐ | ☐ | Anemia | ☐ | ☐ |
| Pressure | ☐ | ☐ | Jaundice or Liver Disease | ☐ | ☐ | Prosthetic Heart Valves | ☐ | ☐ | Asthma | ☐ | ☐ |
| Hepatitis A, B, C | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Prosthetic Hip or Knee | ☐ | ☐ | Arthritis | ☐ | ☐ |
| T.B. or Lung Disease | ☐ | ☐ | Organ transplant | ☐ | ☐ | Bisphosphonates (Osteoporosis) | ☐ | ☐ | Other: _____ | | |

| HAVE YOU BEEN A PATIENT IN A HOSPITAL DURING THE LAST 2 YEARS? ☐ YES ☐ NO | WHEN? | REASON | PHYSICIAN |
|---|---|---|---|
| HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN FOR THE LAST 2 YEARS? | WHEN? | REASON | PHYSICIAN |

ARE YOU ALLERGIC TO:

☐ LATEX ☐ PENICILLIN ☐ CODEINE ☐ LOCAL INJECTED ANESTHETICS ☐ OTHER _____

| ARE YOU SUBJECT TO PROLONGED BLEEDING? | ARE YOU SUBJECT TO FAINTING SPELLS? |
|---|---|

HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH DENTAL TREATMENT? PLEASE EXPLAIN.

| DOES DENTAL TREATMENT MAKE YOU NERVOUS? | HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE (GUM DISEASE?) | WHEN / / | WHAT PROCEDURES WERE PERFORMED? |
|---|---|---|---|

| (WOMEN) ARE YOU PREGNANT? | DUE DATE | PHYSICIAN |
|---|---|---|

| ARE YOU A SMOKER? | HOW MUCH? |
|---|---|

## ALL PATIENTS PLEASE SIGN IN 3 PLACES BELOW:

I UNDERSTAND AND AGREE THAT IN ACCORDANCE WITH SECTION 32.1-45.1 OF THE CODE OF VIRGINIA, THAT IF A HEALTHCARE WORKER IS EXPOSED TO MY BODY FLUIDS IN A MANNER WHICH MAY TRANSMIT HIV OR HEPATITIS B OR C VIRUSES, THEN I DEEM TO HAVE CONSENTED TO TESTING FOR INFECTION WITH HIV OR HEPATITIS B OR C VIRUSES, AND TO THE RELEASE OF SUCH TEST RESULTS TO THE PERSON EXPOSED.

X

SIGNATURE (PATIENT/PARENT/GUARDIAN) DATE

## MEDICAL HISTORY

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

X

SIGNATURE (PATIENT/PARENT/GUARDIAN) DATE

## FINANCIAL POLICY

I AGREE THAT I AM ULTIMATELY THE FINANCIALLY RESPONSIBLE PARTY FOR MY ACCOUNT WITH DRS. GALSTAN AND WARD'S OFFICE (AND FOR THE ACCOUNTS OF PERSONS FOR WHOM I AM ALSO THE FINANCIALLY RESPONSIBLE PARTY), AND REGARDLESS OF INSURANCE COMPENSATION, COVERAGE, PAYMENT, OR ESTIMATED BENEFIT, I AGREE TO PAY THE BALANCE OF MY ACCOUNT(S) IN FULL IN A TIMELY MANNER. A BILLING CHARGE OF 1.5% PER MONTH (18% APR) MAY BE ASSIGNED TO ACCOUNTS 30 OR MORE DAYS PAST DUE. SHOULD COLLECTION ACTION HAVE TO BE TAKEN AGAINST MY ACCOUNT, I AM RESPONSIBLE FOR ALL FEES AND COSTS INCURRED THEREIN, INCLUDING COLLECTION FEES AND ATTORNEY'S FEES OF 33 1/3%. INSURANCE PRETREATMENT ESTIMATES MAY VARY FROM THE FEE THAT IS ACTUALLY CHARGED, WHICH MAY RESULT IN A GREATER OR LESSER BALANCE DUE THAN THAT ORIGINALLY QUOTED OR ANTICIPATED. IN ADDITION, THIS OFFICE RESERVES THE RIGHT TO CHARGE $50 FOR BROKEN OR MISSED APPOINTMENTS, AND $25 FOR APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS NOTICE.

X

SIGNATURE (BENEFICIARY/PARENT/GUARDIAN) DATE

# MEDICAL HISTORY UPDATE

| DATE | Initials | DESCRIPTION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |