WILLIAM C. HENRY, D.D.S., P.C.

POST OFFICE BOX 237
114 E. CITY POINT ROAD
HOPEWELL, VIRGINIA 23860
(804) 458-6020

Welcome to our practice! Here's what to expect at your initial appointment.

When you come in, please bring the patient questionnaire and medical history. These forms are important--they help determine the course of your treatment. We have to know about allergies, sensitivity to anesthetics, long-term medications--your whole health picture.

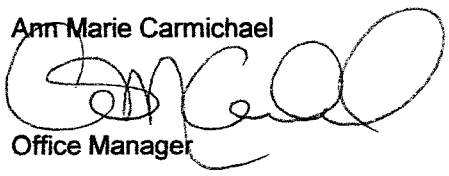
Then we'll need about an hour to examine your teeth, gums, jaw alignment, and soft tissues. We'll take x-rays to find areas of infection that may need treatment. The exam includes a blood pressure check and oral cancer analysis--again, to assess your total health.

Please arrive 15 minutes prior to your scheduled appointment time to complete the registration process. Also, please be sure to bring your current insurance card, a list of any medications you are taking, and any paperwork we mailed to you. If you are unable to keep your appointment, we ask that you kindly give us notice as soon as possible. We like to keep our schedule flexible to better serve our patients. For your convenience we accept all major credit cards, cash, and personal checks.

We look forward to meeting you.

Very truly yours,

Ann Marie Carmichael



Office Manager

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

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

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

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

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

_____ Section 2 _____ Section 3 _____

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Emerg. contact: _____

Emerg. number: _____

Pre-medicate?Yes/No: _____

Reffered by whom?: _____

Your Employer?: _____

Primary Insurance Information

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

WILLIAM C. HENRY, D.D.S. P.C.

MEDICAL HISTORY

PATIENT NAME _____ Birth 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 physician's care now? ( ) Yes ( ) No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ( ) Yes ( ) No If yes, please explain: _____
Have you ever had a serious head or neck injury? ( ) Yes ( ) No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ( ) Yes ( ) No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ( ) Yes ( ) No _____
Are you on a special diet? ( ) Yes ( ) No _____
Do you use tobacco? ( ) Yes ( ) No
Do you use controlled substances? ( ) Yes ( ) No

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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ( ) Yes ( ) No	Cortisone Medicine ( ) Yes ( ) No	Hemophilia ( ) Yes ( ) No	Radiation Treatments ( ) Yes ( ) No
Alzheimer's Disease ( ) Yes ( ) No	Diabetes ( ) Yes ( ) No	Hepatitis A ( ) Yes ( ) No	Recent Weight Loss ( ) Yes ( ) No
Anaphylaxis ( ) Yes ( ) No	Drug Addiction ( ) Yes ( ) No	Hepatitis B or C ( ) Yes ( ) No	Renal Dialysis ( ) Yes ( ) No
Anemia ( ) Yes ( ) No	Easily Winded ( ) Yes ( ) No	Herpes ( ) Yes ( ) No	Rheumatic Fever ( ) Yes ( ) No
Angina ( ) Yes ( ) No	Emphysema ( ) Yes ( ) No	High Blood Pressure ( ) Yes ( ) No	Rheumatism ( ) Yes ( ) No
Arthritis/Gout ( ) Yes ( ) No	Epilepsy or Seizures ( ) Yes ( ) No	High Cholesterol ( ) Yes ( ) No	Scarlet Fever ( ) Yes ( ) No
Artificial Heart Valve ( ) Yes ( ) No	Excessive Bleeding ( ) Yes ( ) No	Hives or Rash ( ) Yes ( ) No	Shingles ( ) Yes ( ) No
Artificial Joint ( ) Yes ( ) No	Excessive Thirst ( ) Yes ( ) No	Hypoglycemia ( ) Yes ( ) No	Sickle Cell Disease ( ) Yes ( ) No
Asthma ( ) Yes ( ) No	Fainting Spells/Dizziness ( ) Yes ( ) No	Irregular Heartbeat ( ) Yes ( ) No	Sinus Trouble ( ) Yes ( ) No
Blood Disease ( ) Yes ( ) No	Frequent Cough ( ) Yes ( ) No	Kidney Problems ( ) Yes ( ) No	Spina Bifida ( ) Yes ( ) No
Blood Transfusion ( ) Yes ( ) No	Frequent Diarrhea ( ) Yes ( ) No	Leukemia ( ) Yes ( ) No	Stomach/Intestinal Disease ( ) Yes ( ) No
Breathing Problem ( ) Yes ( ) No	Frequent Headaches ( ) Yes ( ) No	Liver Disease ( ) Yes ( ) No	Stroke ( ) Yes ( ) No
Bruise Easily ( ) Yes ( ) No	Genital Herpes ( ) Yes ( ) No	Low Blood Pressure ( ) Yes ( ) No	Swelling of Limbs ( ) Yes ( ) No
Cancer ( ) Yes ( ) No	Glaucoma ( ) Yes ( ) No	Lung Disease ( ) Yes ( ) No	Thyroid Disease ( ) Yes ( ) No
Chemotherapy ( ) Yes ( ) No	Hay Fever ( ) Yes ( ) No	Mitral Valve Prolapse ( ) Yes ( ) No	Tonsillitis ( ) Yes ( ) No
Chest Pains ( ) Yes ( ) No	Heart Attack/Failure ( ) Yes ( ) No	Osteoporosis ( ) Yes ( ) No	Tuberculosis ( ) Yes ( ) No
Cold Sores/Fever Blisters ( ) Yes ( ) No	Heart Murmur ( ) Yes ( ) No	Pain in Jaw Joints ( ) Yes ( ) No	Tumors or Growths ( ) Yes ( ) No
Congenital Heart Disorder ( ) Yes ( ) No	Heart Pacemaker ( ) Yes ( ) No	Parathyroid Disease ( ) Yes ( ) No	Ulcers ( ) Yes ( ) No
Convulsions ( ) Yes ( ) No	Heart Trouble/Disease ( ) Yes ( ) No	Psychiatric Care ( ) Yes ( ) No	Venereal Disease ( ) Yes ( ) No
			Yellow Jaundice ( ) Yes ( ) No

Have you ever had any serious illness not listed above? ( ) Yes ( ) No _____

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 _____

Patient Name:_____Date:_____

MEDICATION	*MG*	*FREQUENCY*

WILLIAM C. HENRY, D.D.S., P.C.

PO BOX 237
114 EAST CITY POINT RD.
HOPEWELL, VIRGINIA 23860
(804) 458-6020

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMNT**

NAME:_____ DATE:_____

I,_____ have received a copy of this office's Notice of Privacy Practices.

SIGNATURE:_____

_____

_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgment
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

_____

_____

_____