Scott A. Dunaway, D.D.S., P.C.
www.ValleySmileCare.com

4036 Quarles Court
Harrisonburg, VA 22801
Phone: (540) 433-2800
team@valleysmilecare.com

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)
Gender: _____ Marital Status: _____ Student: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____
E-Mail Address: _____
Address: _____
Street Apartment

_____
City State Zip Code
Employer Name: _____ Occupation: _____
Address: _____ Phone: _____

Emergency Contact/Responsible Party Information

Name: _____ ☐ Male ☐ Female
Social Security #: _____ Birth Date: _____ Relation to Patient: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____
E-mail Address: _____
Address: _____
Street Apartment

_____
City State Zip Code
Employer Name: _____ Occupation: _____
Address: _____ Phone: _____

Insurance Information

Name of Insured: _____
Last First MI
Insured's Birth Date: _____ SSN: _____ Insurance Group #: _____
Insured's Address: _____
City State Zip Code
Insured's Employer Name: _____ Home/Cell#: _____ Work#: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insurance Plan Name and Address: _____
Insurance Company phone number: _____

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Website ☐ Other _____

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Health Information

Date of Last Dental Visit: _____ Reason for this Visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Aids
- ☐ Alzheimer
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Hepatitis
  - ☐ A
  - ☐ B / C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Are you currently pregnant?
  Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Have you ever taken:

- ☐ Redux
- ☐ Fen Phen
- ☐ Fosamax
- ☐ Zometa 10%
- ☐ Aredia 4%
- ☐ Pradaxa

Approx. How long have you been taking the above medication? Or how long on medication previously

Have you ever had any complications following dental treatment?
If yes, please explain: _____
Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, please explain: _____
Have you ever had? Head & Neck Radiation? _____ Head or Neck Injuries _____
Are you allergic to any of these or additional medications or substances? (please check)
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Rubber ☐ Other _____
Are you taking any blood thinners? (please check)
☐ Coudamin ☐ Plavix ☐ Other _____
Are you currently taking any medications? Please list: _____
Do you need to be PRE-MEDICATED prior to your appt due to MVP or Rheumatic Fever? _____
Are you now under the care of physician for medical treatment, excluding routine exams and physicals?
☐ Yes ☐ No If yes, please explain: _____
Name of Physician: _____ Phone _____
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Consent for Services

A condition of your treatment by this office, financial agreements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dentals services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assists in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1 ½% per month (18% per annum) on the unpaid balance will charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to the patient: _____
Signature of patient, parent or guardian