GEORGE TISDELLE, D.D.S.
General & Cosmetic Dentistry

COMPREHENSIVE DENTAL
2214 Ivy Road, Suite 106
Charlottesville, VA 22903
434-295-6880

DARLENE NICOLETTI, D.D.S.
Periodontics

Patient Information

Patient Name: ____ Date: ____________________

Last First Mi

Please circle: Male Female Married Single Child Other:____________________

Social Security # ______________________Birth Date ________________ E-Mail ____________________

Phone (Home): ______________________ (Work):________________________(Cell):____________________

Address: ____

Street Apt. # City State Zip

Health Information

1. Have you been admitted to a hospital or needed emergency care during the past two years?
   Please circle: YES NO
   If yes, please explain: ____
2. Are you now under the care of a physician? Please circle YES NO
   If yes, please explain: ____
   Name of Physician: ____Phone:_________________________
   ____
3. Are you currently taking any medications? Please circle YES NO
   If yes please list: ____
   ____
4. Have you ever had any of the following? Please circle those that apply

Allergies____________	Dizziness/ Fainting	Jaundice	Respiratory Problems/Inhaler
Anemia/Blood Disorders	Excessive Bleeding	Kidney Disease	Sinus Problems
Arthritis/Rheumatism	Glaucoma	Latex Allergy	Stomach Problems
Artificial Joint/Implants/	Hay Fever	Liver Disease	Stroke
or Valves	Head injuries	Pacemaker	STD
Asthma	Heart Disease	Penicillin Allergy	Sulfa Allergy
Cancer________	Heart Murmur	Currently Pregnant	Tuberculosis
Chemotherapy	Hepatitis	Due Date _______	Ulcers
Diabetes	High Blood Pressure	**Premedicate**	
Digestive Problems	HIV	Radiation Treatment	

   Do you have any other conditions not listed above? ____
5. Do you smoke cigarettes or use any tobacco products? Please circle YES NO
   If yes, how many packs? _______________
6. Date of last dental Visit:________________ Reason for today's visit: ____________________________________

   Please circle Yes or No for the questions below:
7. Do you like your smile? Yes No
8. Are you interested in Tooth Whitening? Yes No
9. Have you have had any complication following dental treatment? YES NO
   If yes please explain: ____
10. Do you avoid brushing any part of your mouth because of pain or sensitivity? YES NO
11. Do you clench or grind your teeth while sleeping or during the day? YES NO
12. Are you apprehensive (nervous) about your dental treatment? YES NO

    To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at my next appointment without fail.

____

Signature of patient, parent or guardian Date

Referral Information

Whom may we thank for referring you to our practice? Please Circle.

Another patient	UVA Directory	Location	Yellow Pages	Employer
Newspaper/Magazine	Insurance Company	Web Page/Internet	Other____________________________	

Name of the person or office referring you to our practice: ____
____

Patient Employer

Employee Name: ____
Occupation/Employer____
Address:____

Dental Insurance Information

Claims cannot be submitted without complete insurance information

Insurance Subscriber: ____
Subscribers Birth date: _________________________ Subscribers ID #_______________________________________
Group #: ___________________________________Employer Name: ____
Relationship to Patient: Please circle.

Self	Spouse	Child	Other ______________

Insurance Plan Name, Address and Phone #: ____
____
____

Consent of Services

As a condition or your treatment by this office, financial arrangements 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 service performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patents who carry dental insurance understand that all dental 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 form or assist 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 1.5% per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 60days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for 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 of payment, thereof. I further agree that a waiver of any breach of anytime of 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 permission to you and your assignee, to telephone me at home or at any work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signature of patient, parent/guardian: ____

Relationship to patient: ____Date_________________________