GEORGE TISDELLE, D.D.S., P.C.
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General & Cosmetic Dentistry and Periodontics
2214 Ivy Road, Suite 106
Charlottesville, VA 22903
434-295-6880

Patient Information

Patient Name: ____ Date: _____________________
Last First Middle

Please place an X next to those that apply: ___Male ___Female ___Married ___ Single ___Child Other:_____

Social Security # _______________________Birth Date _____________ E-Mail ___________________________

Phone (Home): ___________________ (Work):______________________(Cell):_________________________

Address:

____
Street Apt. # City State Zip

How would you prefer to be contacted? ____

Health Information

1. Have you been admitted to a hospital or needed emergency care during the past two years? ___ Yes ___No
If yes, please explain:____

2. Are you now under the care of a physician? ___ Yes ___No
If yes, please explain:____
Name of Physician: ____Phone:_____________________________

3. Are you currently taking any medications? ___ Yes ___No
If yes please list: ____
____

4. Have you ever had any of the following? Please place an 'X' next to those that apply

___Allergies _________________
___Anemia/Blood Disorders
___Arthritis/Rheumatism
___Artificial Joint/Implants/or Valves
___Asthma
___Cancer ___________________
___Chemotherapy
___Diabetes
___Digestive Problems
___Dizziness/Fainting
___Excessive Bleeding
___Glaucoma
___Hay Fever
___Head Injuries
___Heart Disease
___Heart Murmur
___Hepatitis
___High Blood Pressure
___HIV
___Jaundice
___Kidney Disease
___Latex Allergy
___Liver Disease
___Pacemaker
___Penicillin Allergy
___Pregnant (Due Date________)
___Premedicate
___Radiation Treatment
___Respiratory Problems/Inhaler
___Sinus Problems
___Stomach Problems
___Stroke
___Sulfa Allergy
___Tuberculosis
___Ulcers

Do you have any other conditions not listed above?
____

5. Do you smoke cigarettes or use any tobacco products? ___Yes ___No If yes, how many packs? _______

Dental Information

Please place an 'X' next to Yes or No for the questions below

1. Date of last dental Visit:________________ Reason for today's visit: ____________________________________
2. Do you like your smile? ___Yes ___No
3. Are you interested in Tooth Whitening? ___Yes ___No
4. Have you have had any complication following dental treatment? ___Yes ___No

If yes please explain:
____

5. Do you avoid brushing any part of your mouth because of pain or sensitivity? ___Yes ___No
6. Do you clench or grind your teeth while sleeping or during the day? ___Yes ___No
7. 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/guardian: ____

Relationship to patient: ____Date________________________

Referral Information

Whom may we thank for referring you to our practice? Please place an 'X' next to those that apply.

___Another Patient ___Facebook ___Employer
___Newspaper/Magazine ___Website/Internet ___Insurance Company

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

Patient Employer

Employer: ___________________________________ Occupation: ___________________________________
Address:____
Phone:____

Dental Insurance Information

Claims cannot be submitted without complete insurance information
Insurance Plan Name, Address and Phone #: ____
____
Insurance Subscriber: ____
Subscribers Birth date: ________________________ Subscribers ID #____________________________________
Group #: _________________________________Employer Name: _______________________________________
Relationship to Patient: ___Self ___Spouse ___Child Other _____________

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.
Patients 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________________________