Amos Family Dentistry, LLC
Robert W. Amos, DDS
Patient Information and Dental History

Patient's Name:_______________________ DOB:_____________ Sex: M /F Age:________
Home Address:__________________________ City:___________ State:_____ Zipcode:_______
Billing Address (if different):___________________ City:__________ State:____ Zipcode:_____
Home phone:___________________ Cell:_________________ E-mail:______________________

Driver's License #:______________________ State:_________________
SS #:____________________ Employer/Occupation:______________________
Work phone:______________________
Spouse's Name:_____________________________ Spouse's phone:______________________
Emergency contact and phone:____
Referred by:________________________________

Insurance

Primary dental insurance:______________________ Group #:____________________________
Secondary dental insurance:____________________ Group #:____________________________
Subscriber's Name:___________________________ DOB:____________ SS #:______________

Dental History

Previous Dentist:______________________________ Date of last visit:_____________________
Date of last X-rays:_____________________________
How often do you brush?___________________ How often do you floss?___________________
Do you use a mouthrinse? Y/N
Do you use fluoride supplements? Y/N
Do you smoke? Y/N
Do you use smokeless tobacco? Y/N
Do you have a history of smoking or using smokeless tobacco? Y/N
Do you have jaw pain? Y/N
Do you like your smile? Y/N
Would you like your teeth to be whiter? Y/N
Do you have any dental related concerns? Y/N
Please explain :____
____
____
____
____

Have you had any bad dental experiences? Y/N
Please explain: ____
____
____
____
____

Amos Family Dentistry, LLC
Robert W. Amos, DDS
Medical History Questionnaire

Patient's Name:________________________________ Today's Date:________________
Date of Birth:__________________________
Physician's Name:______________________ Date of Last Visit:_____________

Please check if you have the following::

- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial heart valves
- ❑ Artificial joint replacement
  - ❑ Year of replacement:_______
- ❑ Asthma
- ❑ Autoimmune Disease
- ❑ AIDS/HIV
- ❑ Blood Disease
- ❑ Abnormal bleedings, prolonged healing, bruising easily
- ❑ Cancer
  - ❑ Diagnosis:_______________
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Diabetes
  - ❑ A1C:________
- ❑ Epilepsy/seizures
- ❑ Fainting/dizziness
- ❑ Glaucoma/eye disorders
- ❑ Headaches/migraines
- ❑ Heart murmur
- ❑ Heart disease
  - ❑ Describe;_______________
- ❑ Hemophilia
- ❑ Hepatitis/liver disease/jaundice
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Kidney disease
- ❑ Pacemaker
- ❑ Psychiatric care
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Shortness of breath
- ❑ Skin rash
- ❑ Stroke
- ❑ Congestive heart failure
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Ulcer/digestive disorders
- ❑ Venereal disease

Women:

- ❑ Are you pregnant Y/N
- ❑ Nursing Y/N
- ❑ Taking birth control pills? Y/N
- ❑ Other:________________________

Medications:

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

Allergies:

______________________________________ ______________________________________
______________________________________ ______________________________________

Patient Signature:_______________________

Amos Family Dentistry, LLC
Robert W. Amos, DDS
General Dentistry Care Consent Form

Patient's Name:_______________________________________ Date:_________________

Welcome to our office. We appreciate the confidence you have placed with us to provide your dental care.

I understand dentistry is not an exact science and there is no guarantee of specific results. For the best results, it is imperative that I work together with the dental care team. This means that I will strive to keep all appointments and arrive on time. Cooperation and participation is imperative for the desired outcome.

I understand the dental care team will recommend procedures. The dental team will do their best to make sure I understand their care and plan. If I do not understand any of the treatments or the plan, I will discuss it with the dental team. I understand if I do not fulfill my part of the agreement by following their advice, I will be hampering the outcome of my treatment.

I understand that should I feel there are changes in my condition or symptoms appear between scheduled visits, I should notify the office immediately.

Patient's Signature:____

Amos Family Dentistry, LLC
Robert W. Amos, DDS
Consent/Authorization Form for Use and Disclosure of Patient Information

Printed Name:_________________________________ Date:________________
DOB:__________________ Email:_____________________________________

I authorize the following person(s) to receive this patient information:

Name:	Relationship:

I understand that I may revoke this authorization at anytime, and that my revocation is not effective unless it is in writing and received by the Amos Family Dentistry at 1002 Amherst Street, Suite A, Winchester, VA 22601.
I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollments in a healthplan, or eligibility for benefits.

Patient Signature:____
If patient has Guardian:

Print Guardian Name:_________________________________
Signature:____ Relationship:_____________

FOR OFFICE USE ONLY:
- ❏ Individual refused to sign Initials:___________

Amos Family Dentistry, LLC
Robert W. Amos, DDS
Acknowledgement of Receipt of Notice of Privacy Practices
*you may refuse to sign this acknowledgement

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

Printed Name:____

Signature:____ Date:_________________

FOR OFFICE USE ONLY:

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

- ❏ Individual refused to sign
- ❏ Communication barriers prohibited obtaining the acknowledgement
- ❏ An emergency situation prevented us from obtaining acknowledgement
- ❏ Other (please specify) ____
  ____
  ____
  ____

Amos Family Dentistry, LLC
Robert W. Amos, DDS
Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:

1. Cash
2. Check
3. Credit cards
4. Credit Card authorization for recurring charges
    a. Treatment exceeds $200
    b. Plan may not exceed 4 months

Patient with insurance: The patient is responsible for the estimated non-covered portion, procedures and/or deductibles at the time of the service. OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their child to an appointment must make prior arrangements for payment (cash, check or credit card authorization).

Parents accompanying their child are financially responsible for payment.

The account is the responsibility of the patient. Accounts with balances beyond 45 days are turned over to a **collection attorney** (unless prior arrangements have been made with our office). In the event outside collections services are necessary, you will be responsible for attorney's fees (33.3%), court costs and interest.

18% annual interest is charged for any unpaid balance. A $15 fee is charged for nonpayment. There is a $30 processing fee for non-sufficient funds or returned checks.

Records can be viewed at anytime. There is a nominal charge for release of copies of records of $10.

There will be a charge of $25-$50 for missed or changed appointments with less than 24 hour notice.

Please sign below if you are in agreement with these financial terms.

Patient/Patient's Guardian Signature:___________________________ Date:_________