Brendan Bernhart, D.D.S., P.C.
Prosthodontics & Maxillofacial Prosthetics
3020 Hamaker Court, Suite 510
Fairfax, VA 22031
Phone: (703) 645-8001 ♦ Fax: (703) 645-8002

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: ☐ M ☐ F Family Status: ☐ Single ☐ Married ☐ Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐ M ☐ T ☐ W ☐ Th

E-mail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

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/HIV Positive
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chemotherapy
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease/Failure
☐ Heart Murmur/ Mitral Valve Prolapse
☐ Hemodialysis
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders/ Psychiatric Care
☐ Nervous Disorders
☐ Neurologic Condition
☐ Pacemaker
☐ Pneumonia
☐ **Pregnancy** Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems/ Emphysema
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Vascular Surgery
☐ Venereal Disease
☐ Codeine Allergy
☐ Latex Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification and/or are not listed above? ☐ Yes ☐ No
  If yes, please explain: _____

- Are you now taking or have you taken in the previous month any prescription medications (drugs) or OTC/ nonprescription/natural/herbal supplement/vitamin products? ☐ Yes ☐ No

Medication	Dosage (mg/units/mL)	Number of times per day	Date Started

- Are you allergic or have you had a reaction to any drugs/medications? ☐ Yes ☐ No

  If yes, please describe: _____

- Have you ever bled excessively after an injury or tooth extraction? ☐ Yes ☐ No
- Are you ever short of breath after mild exertion/activity (example: climbing a flight of stairs)? ☐ Yes ☐ No
- Have you had unexplained weight loss, night sweats, or chronic cough? ☐ Yes ☐ No
- Have you had any dental X-rays made in the past year? ☐ Yes ☐ No
- Have you ever had an injury to your face or jaws? ☐ Yes ☐ No
- Do you use tobacco in any form? ☐ Yes ☐ No

  ☐ Chew ☐ Dip ☐ Cigarette ☐ Cigars ☐ Pipe Number of months or years: _____

- Have you had surgery for a tumor or growth on your mouth, face or neck? ☐ Yes ☐ No
- Women: Are you pregnant now ? (Please answer yes if you are not sure) ☐ Yes ☐ No

  Are you taking birth control pills? ☐ Yes ☐ No

  Are you using another form of contraception? ☐ Yes ☐ No

  Do you anticipate becoming pregnant? ☐ Yes ☐ No

  Are you currently or do you plan to breast-feed? ☐ Yes ☐ No

  Are you past menopause? ☐ Yes ☐ No

I certify that I have read and understand the above information. 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 my doctor at the next appointment without fail. I will not hold my dentist or any other member of his staff responsible for any errors or omissions made in the completion of this form

_____ Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Consent for Services

As a condition of 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 services performed without previous financial arrangements, must be paid for at the time services are performed.

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 patient's insurance forms or provide documentation regarding treatment to insurance companies if necessary to expedite reimbursement to the patient. If I request that this office help with preparation of insurance claims, I authorize the release of any medical or other information necessary to process the claim. This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that I may apply for a monthly payment plan through CareCredit or CapitalOne healthcare finance to cover dental expenses. Information regarding the terms and conditions of the monthly payment plans is available upon request.

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. 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.

In order to ensure the lowest possible pricing and the highest level of service to you, we are implementing a new system that will reduce our billing costs yet maintain the quality of service that you require and deserve. All accounts that go beyond 60 days past due may be transferred to Transworld Systems, a national collection agency, for account receivable assistance. Should this be necessary, a service fee of $20 may be added to your account as well as interest, if applicable.

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.

Signature of patient, parent or guardian

_____ Date: _____

Signature of guarantor of payment/responsible party

_____ Date: _____