Dr. Richard Byrd & Associates
ORTHODONTICS & PEDIATRIC DENTISTRY

9221 Forest Hill Ave • Richmond • VA 23235 2929 Polo Parkway • Midlothian • VA 23113

PATIENT INFORMATION

Who Referred You/How Did You Hear About Us?_____

Patient Name: First_____Middle Initial_____Last_____
Preferred Name:_____ **Date Of Birth**_____/_____/_____ **SSN**_____-_____-_____
Marital status: □ Single □ Partnered □ Married □ Divorced **Gender:** □ Male □ Female
Home Address: _____
Street City, State Zip Code
Home Phone: (_____)_____**Cell Phone:** (_____)_____ **Work Phone:** (_____)_____
Preferred Contact for appointment reminder: □ Home □ Cell □ Work □ Text
Email:_____
Parent/Legal Guardian:_____ **Relationship:**_____
Child Lives With: □ Check if same as above _____
Home Address: _____
Street City, State Zip Code
Home Phone: (_____)_____**Cell Phone:** (_____)_____ **Work Phone:** (_____)_____

Emergency Contact:_____ **Relationship:**_____
Home Address: _____
Street City, State Zip Code
Home Phone: (_____)_____**Cell Phone:** (_____)_____ **Work Phone:** (_____)_____

Information of person responsible for payment (If different from patient):
Name:_____ Relationship:_____
Date Of Birth_____/_____/_____ SSN_____-_____-_____
Home Address: _____
Street City, State Zip Code
Home Phone: (_____)_____Cell Phone: (_____)_____ Work Phone: (_____)_____
If you are covered by Dental Insurance, Please complete the following:
Name of Insurance Company (Primary): _____
Name of Policy Holder: _____
Employer (If through Occupation): _____
Date Of Birth : _____/_____/_____ SSN : _____-_____-_____ Group Number: _____
Name of Insurance Company (Secondary): _____
Name of Policy Holder: _____
Employer (If through Occupation): _____
Date Of Birth : _____/_____/_____ SSN : _____-_____-_____ Group Number: _____
Authorization and Release of Information:
I agree that my dental insurance carrier may be billed for services provided and payment will be made directly to Dr. Richard Byrd & Associates. I also assume responsibility for any portion of the treatment cost not covered by my insurance carrier. I hereby give authorization for the release of any information requested or required by my insurance carrier with respect to any insurance claims.

_____ _____ _____
Patient/Parent/Responsible Party Signature Relationship to Patient Date

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HEALTH HISTORY

Although dental personnel primarily treat the area in and around the mouth, the mouth is part of the entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental treatment you will receive. Thank you for answering the following questions. (**To be filled out by or on behalf of the patient**)

Are you under a physician's care now? □ Yes □ No If yes, explain_____
Have you ever been hospitalized? □ Yes □ No If yes, explain_____
Have you had a major surgery/operation? □ Yes □ No If yes, explain_____
Have you had a serious neck or head injury? □ Yes □ No If yes, explain_____

List medications, dosage, and reason for taking:
Please ask for additional paper if necessary

Medications	Dosage	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to the following: □ Latex □ Penicillin □ Aspirin □ Codeine □ Acrylic □ Local Anesthetics □ Type(s) of Metal:_____ □ Other:_____

Do you have, or have you had, any of the following:

- □ AIDS/HIV Positive
- □ Anemia
- □ Angina
- □ Artificial Heart Valve
- □ Artificial Joint
- □ Asthma
- □ Blood Disease
- □ Blood transfusion
- □ Breathing Problem
- □ Bruise Easily
- □ Cancer
- □ Chemotherapy
- □ Hives or Rash
- □ Ear tubes
- □ Chest Pains
- □ Cold/Sores/Fever Blisters
- □ Congenital Heart Disorder
- □ Convulsions
- □ Cortisone Medicine
- □ Diabetes
- □ Epilepsy or Seizures
- □ Excessive Bleeding
- □ Excessive Thirst
- □ Fainting Spells/dizziness
- □ Frequent Cough
- □ Frequent Diarrhea
- □ Renal Dialysis
- □ Recurrent ear infections
- □ Frequent Headaches
- □ Genital Herpes
- □ Hay Fever
- □ Heart Attack
- □ Heart Murmur
- □ Heart Pace Maker
- □ Heart Trouble
- □ Hemophilia
- □ Hepatitis A
- □ Hepatitis B or C
- □ Herpes
- □ High Blood Pressure
- □ Ulcers
- □ Hearing loss
- □ Irregular heartbeat
- □ Kidney Problems
- □ Leukemia
- □ Liver Disease
- □ Low Blood Pressure
- □ Lung Disease
- □ Mitral Valve Prolapse
- □ Pain in Jaw Joints
- □ Parathyroid disease
- □ Psychiatric Care
- □ Radiation Treatments
- □ Recent Weight Loss
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Shingles
- □ Sickle Cell Disease
- □ Sinus Trouble
- □ Spina Bifida
- □ Stomach/Intestinal Disease
- □ Stroke
- □ Swelling of Limbs
- □ Thyroid Disease
- □ Tonsillitis
- □ Tuberculosis
- □ Tumors or Growths
- □ Yellow Jaundice

Please list any other illness or condition not listed above:_____
_____

Behavioral Concerns (i.e. ADHD, Autism, Depression, or Anxiety)**:**_____
Name of Physician_____ **Phone:** (_____)_____

Women Only:

Are you pregnant or think you may be pregnant? □ Yes □ No
Are you nursing? □ Yes □ No
Are you on birth control? □ Yes □ No

To the best of my knowledge, the questions on this Health History Form have been accurately. I understand that withholding information or providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform Dr. Richard Byrd & Associates of any changes in medical status.

_____ _____ _____
Patient/Parent/Responsible Party Signature Relationship to Patient Date