WELCOME

Dr. Randy Norbo, DDS, PC • 1414 Franklin Rd. S.W. • Suite 3 • Roanoke, VA 24016 • 540-344-4798

1 PATIENT INFORMATION

Date____/____/____ SSN #_____

Patient Name_____
Last Name

_____
First Name Middle Initial

Email_____

Address_____

City_____

State_____ Zip_____

Sex ☐ M ☐ F Age____ Birthdate____/____/____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for____yrs

Patient Employer/School/College_____

Occupation_____

Employer/School Address_____

_____

Employer/School Phone ( )_____

Spouse's Name_____

Birthdate____/____/____ SSN#_____

Spouse's Employer_____

Whom may we thank for referring you?_____

2 DENTAL INSURANCE

Insurance Co._____ Group #_____

Subscriber's Name_____

Birthdate____/____/____ SS#_____ ID#_____

Relationship to Patient_____

SECONDARY INSURANCE

Insurance Co._____ Group #_____

Subscriber's Name_____

Birthdate____/____/____ SS#_____ ID#_____

Relationship to Patient_____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with the above named company and assign directly to Dr. Randy J. Norbo all insurance benefits, if any, otherwise payable to me for services rendered. I understand that **I am financially responsible for all changes** whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and my disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

X_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____
Date Relationship to Patient

3 PHONE NUMBERS

Home ( )_____ Work ( )_____ Ext.____ Cell ( )_____

Spouse's Work ( )_____ Best time and place to reach you_____

Emergency Contact Name_____ Relationship_____
(Specify someone who does not live in your household)

Home Phone ( )_____ Work ( )_____

4 RESPONSIBLE PARTY

Name of Person Responsible for Account_____ Relationship to Patient_____

Address_____ Home Phone ( )_____

Driver's License #_____ Birthdate____/____/____

Currently a Patient in our office: Yes ☐ No ☐ Email_____ Cell ( )_____

5 DENTAL HISTORY

Reason for today's visit_____

_____

Former Dentist_____

City/State_____

Date of last dental visit_____

Date of last dental x-ray_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath Yes ☐ No ☐

Bleeding Gums Yes ☐ No ☐

Blisters on lips or mouth Yes ☐ No ☐

Burning Sensation on tongue Yes ☐ No ☐

Chew on side of mouth Yes ☐ No ☐

Cigarette, pipe or cigar smoker Yes ☐ No ☐

Smokeless tobacco use Yes ☐ No ☐

Clicking or popping jaw Yes ☐ No ☐

Dry mouth Yes ☐ No ☐

Fingernail biting Yes ☐ No ☐

Food collection between teeth Yes ☐ No ☐

Grinding teeth Yes ☐ No ☐

Gums swollen or tender Yes ☐ No ☐

Jaw pain or tiredness Yes ☐ No ☐

Lip or Cheek biting Yes ☐ No ☐

Loose teeth or broken fillings Yes ☐ No ☐

Mouth Breathing Yes ☐ No ☐

Mouth pain, brushing Yes ☐ No ☐

Orthodontic treatment Yes ☐ No ☐

Pain around ear Yes ☐ No ☐

Periodontal treatment Yes ☐ No ☐

Sensitivity to cold Yes ☐ No ☐

Sensitivity to heat Yes ☐ No ☐

Sensitivity to sweets Yes ☐ No ☐

Sensitivity when biting Yes ☐ No ☐

Sores or growths in mouth Yes ☐ No ☐

How often do you floss?_____

_____

How often do you brush?_____

_____

6 HEALTH HISTORY

Physican's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs to strengthen bones (bisphosponate)? Yes ☐ No ☐

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV Yes ☐ No ☐

Anemia Yes ☐ No ☐

Arthritis, Rheumatism Yes ☐ No ☐

Artificial Heart Valves Yes ☐ No ☐

Artifical Joints (pre-med) Yes ☐ No ☐

Year_____

Asthma Yes ☐ No ☐

Back Problems Yes ☐ No ☐

Bleeding abnormally, (extractions or surgery) Yes ☐ No ☐

Blood Disease Yes ☐ No ☐

Cancer Yes ☐ No ☐

Chemical Dependency Yes ☐ No ☐

Chemotherapy Yes ☐ No ☐

Circulatory Problems Yes ☐ No ☐

Congenital Heart Lesions Yes ☐ No ☐

Cortisone Treatments Yes ☐ No ☐

Cough, persistent or bloody Yes ☐ No ☐

Diabetes (insulin controlled) Yes ☐ No ☐

Emphysema Yes ☐ No ☐

Epilepsy Yes ☐ No ☐

Fainting or Dizziness Yes ☐ No ☐

Glaucoma Yes ☐ No ☐

Headaches Yes ☐ No ☐

Heart Murmur Yes ☐ No ☐

Heart Problems (Pre-med) Yes ☐ No ☐

Hepatitis Type_____ Yes ☐ No ☐

Herpes Yes ☐ No ☐

High Blood Pressure Yes ☐ No ☐

Jaundice Yes ☐ No ☐

Jaw Pain Yes ☐ No ☐

Kidney Disease Yes ☐ No ☐

Liver Disease Yes ☐ No ☐

Low Blood Pressure Yes ☐ No ☐

Mitral Valve Prolapse Yes ☐ No ☐

Nervous Problems Yes ☐ No ☐

Pacemaker Yes ☐ No ☐

Radiation Treatment Yes ☐ No ☐

Respiratory Disease Yes ☐ No ☐

Rheumatic Fever Yes ☐ No ☐

Scarlet Fever Yes ☐ No ☐

Shortness of Breath Yes ☐ No ☐

Sinus Trouble Yes ☐ No ☐

Skin Rash Yes ☐ No ☐

Stroke Yes ☐ No ☐

Swollen Feet or Ankles Yes ☐ No ☐

Swollen Neck Glands Yes ☐ No ☐

Thryoid Problems Yes ☐ No ☐

Tuberculosis Yes ☐ No ☐

Tumor or growth on head/neck Yes ☐ No ☐

Ulcer Yes ☐ No ☐

Venereal Disease Yes ☐ No ☐

Weight Loss, unexplained Yes ☐ No ☐

Women: Are you pregnant? Yes ☐ No ☐ Due Date_____ Are you Nursing? Yes ☐ No ☐ Taking Birth Control? Yes ☐ No ☐

MEDICATIONS: Please list medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name_____ Phone Number ( )_____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping Pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex ☐ NONE_____

Notice of Privacy Practices Acknowledgement

RANDY J. NORBO, DDS, PC
1414 Franklin Road S.W. Suite 3
Roanoke, Virginia 24016
540 • 344 • 4798

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature: X_____

Date:_____

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date:_____ Initials:_____Reason:_____

_____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

X _____ _____

Signature of Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Parent, Guardian or Personal Representative — Relationship to Patient

PERMISSION FOR TREATMENT

This is to certify that I, undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated; and I will assume responsibility for fees associated with those procedures.

X _____ _____

Signature of Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Parent, Guardian or Personal Representative — Relationship to Patient

CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if my minor ever has a change in health.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____

Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

SIGNIFICANT EXPOSURE

SIGNIFICANT EXPOSURE-Section 32.1-45.1(A) and (B), Code of Va. (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitus virus is considered to have been given by the patient and/or healthcare worker thereby granting a medical facility the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of the local medical facility.

Thank You

We would like to thank you for choosing our office for your dental needs. Our policy is to provide you with the best treatment possible with the most current techniques available. Most important, we are here to help you and your family in a comfortable environment. We are available to answer any questions regarding your care or financial needs. Thank you for placing your trust in our practice.

Cancellation Policy

RANDY J. NORBO, DDS, PC
1414 Franklin Road S.W. Suite 3
Roanoke, Virginia 24016
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Dr. Randy Norbo and his staff strive to provide excellent care to each patient in a timely manner. In order for us to deliver care in the most efficient and effective way, we ask that you inform us if you are unable to attend your scheduled appointment. Your notification allows us to better utilize available appointments for other patients in need of dental care, as our time is as important as yours.

If it is necessary to cancel your appointment, we require that you call at least 24 hours before your appointment time. We reserve that right to charge a $40.00 fee for any scheduled appointments that are:

- Cancelled with less than 24 hours notice
- Broken appointment (the patient does not show for the appointment)

Cancellation fees cannot be billed to the insurance company; therefore it will be your responsibility for payment.

Please be aware if you are more than 15 minutes late for your appointment, you may be asked to reschedule.

By signing below I agree to uphold my appointment times and understand the above explained cancellation policy.

Patient Signature: X_____ Date:_____

Printed Patient Name _____

Patient Date-of-Birth _____