Steadman Family Dentistry
Stony Point Medical Park
9220 Forest Hill Ave., Ste. A5
Richmond, VA 23235

Steadman
Family Dentistry

Drs. Robert & Grant Steadman
Phone: 804-272-3200
Fax: 804-330-5516
www.steadmandental.com

NEW PATIENT INFORMATION

Please remember to bring your insurance card and a photo ID to your first visit. Thank you!

GENERAL INFORMATION

Last Name: _____ First Name: _____ MI: ___ Preferred Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Would you like to recieve text messages to your cell phone with appointment reminders? ☐ *Yes* ☐ *No*

Email Address: _____ *May we contact you via email?* ☐ *Yes* ☐ *No*

Social Security Number: _____ Date of Birth*(MM/DD/YY)*: _____ Sex: ☐ *Male* ☐ *Female*

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

How did you hear about us? ☐ *Current Patient or Dr. Name:* _____ ☐ *Other:* _____

Preferred Pharmacy: _____

Medical Alerts: _____

PRIMARY DENTAL INSURANCE

Subscriber Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: ____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Employer: _____

Employer Address: _____ City, State, Zip: _____

Insurance Company: _____ Group/Plan#: _____

Insurance Co. Address: _____ City, State, Zip: _____

SECONDARY DENTAL INSURANCE

Subscriber Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: ____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Employer: _____

Employer Address: _____ City, State, Zip: _____

Insurance Company: _____ Group/Plan#: _____

Insurance Co. Address: _____ City, State, Zip: _____

CONSENT

The undersigned hereby authorizes the doctor(s) to take X-rays, study models, photographs, or use any other aids deemed appropriate by the doctor(s) to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor(s) to perform any and all forms of treatment, medication and therapy that may be indicated in connection with(name of patient) _____ and further authorize and consent that the doctor(s) choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies certain risks. I understand the responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge(18% annually) will be added to any balance over 60 days. In the event of default I/we promise to pay legal interest on the indebtness, together with all costs of collections, including attorney fees of 33.3% may be required to effect collection of this note.

Printed Name of Patient (or Patient Representative): _____

Signature of Patient (or Patient Representative): _____ *Date:* _____

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MEDICAL HISTORY & GENERAL HEALTH INFORMATION

Before starting treatment, we need some basic health information to ensure we provide the best oral care possible. All information is confidential.

GENERAL INFORMATION

Patient Name:_____ Date of Birth*(MM/DD/YY)*:_____

Who is your Primary Care Physicia(PCP)?_____ Last Exam Date:_____

Please list any medication(s) you are currently taking:_____

_____

Are you allergic to: Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Household Bleach

Please list any other allergies:_____

Have you ever taken: Phen-Fen Redux Fosamax Boniva Actonel Other Bisphosphonate:_____

Have you ever been hospitalized, had a major operation, or had a major injury to your head or neck? *Yes* *No*

_____

Are you taking any herbal suppplements or on a special diet? *Yes* *No* _____

Do you currently use or have you ever used tobacco products? *Yes* *No* _____

Do you use any controlled substances? *Yes* *No* _____

WOMEN

Are you currently pregnant or trying to get pregnant? *Yes* *No* Are you currently nursing? *Yes* *No*

Are you currently taking oral contraceptives? *Yes* *No* _____

MEDICAL CHECKLIST *(Please check all that apply)*

All information is kept strictly confidential.

AIDS/HIV Positive	Convulsions	Hepatitis A	Radiation Treatments
Alzheimer's Disease	Cortisone Medicine	Hepatitis B or C	Recent Weight Loss
Anaphylaxis	Diabetes	Herpes	Renal Dialysis
Anemia	Drug Addiction	High Blood Pressure	Rheumatic Fever
Angina	Emphysema	High Cholesterol	Scarlet Fever
Arthritis/Gout	Epilepsy or Seizures	Hives or Rash	Shingles
Artificial Heart Valve	Excessive Bleeding	Hypoglycemia	Sickle Cell Disease
Artificial Joint	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Asthma	Frequent Cough	Kidney Problems	Spina Bifida
Blood Disease	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Blood Transfusion	Frequent Headaches	Liver Disease	Stroke
Breathing Problems	Glaucoma	Low Blood Pressure	Swelling of Limbs
Bruise Easily	Hay Fever	Lung Disease	Thyroid Disease
Cancer	Heart Attack/Failure	Mitral Valve Prolapse	Tonsillitis
Chemotherapy	Heart Murmur	Osteoporosis	Tuberculosis
Chest Pains	Heart Pacemaker	Pain in Jaw Joints	Ulcers
Cold Sores/Fever Blisters	Heart Trouble/Disease	Parathyroid Disease	Yellow Jaundice
Congenital Heart Disorder	Hemophilia	Psychiatric Care	Other: *(please detail below)*

Have you had a serious illness not listed above? *Yes* *No* *If yes, please detail below*_____

_____

_____

CONSENT

I certify that the questions on this form have been answered accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my(or the patient's) health, and that it is my responsibility to notify the dental office of any changes in medical status. I also understand that this consent will remain in effect until treatment is terminated either by myself or the dentist.

*Printed Name of Patient (or Patient Representative):*_____

*Signature of Patient (or Patient Representative):*_____ *Date:*_____