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

Steadman Family Dentistry

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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:* _____