

KENNETH E. STONER, D.D.S., AND ASSOCIATES, P.C.

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THE
WILLOW
PROFESSIONAL
BUILDING

MISSED APPOINTMENT POLICY

TO OUR PATIENTS:

Due to the high cost of no-show appointments we will be obligated to charge you (**not your insurance**) a fee if you do not call and cancel your appointment twenty-four (24) hours in advance.

The missed appointment policy will be as follows:

1/2 hour appointment	\$35.00
45 minute appointment	\$45.00
1 hour appointment	\$55.00
1 1/2 hour appointment	\$95.00

Please sign that you have read and understand the above missed appointment policy.

Signature of patient or parent: _____

Date: _____

Witnessed by: _____

Dental History

Patient's Name _____

Welcome!

*So that we may provide you with the best possible care,
please complete both sides of this dental/medical history form.
All information is completely confidential.*

What is the reason for your visit today? _____

Date of Last Dental Visit: _____ **Last Dental Cleaning:** _____ **Last Full Mouth X-rays:** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ City _____ State _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aides do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? YES NO

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or Cold?	YES	NO
Sweets?	YES	NO
Biting or Chewing?	YES	NO
Have you noticed any mouth odors or bad tastes?	YES	NO
Do you frequently get cold sores, blisters or any other oral lesions?	YES	NO

Do your gums bleed or hurt? YES NO

Have your parents experienced gum disease or tooth loss?	YES	NO
Have you noticed any loose teeth or change in your bite?	YES	NO
Does food tend to become caught in between your teeth?	YES	NO
If yes, please explain where:		

Do you:

Clench or grind your teeth while awake or asleep?	YES	NO
Bite your lips or cheeks regularly?	YES	NO
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	YES	NO
Mouth breath while awake or asleep?	YES	NO
Have tired jaws, especially in the morning?	YES	NO
Smoke/chew tobacco?	YES	NO
Do you smoke heavily?	YES	NO

Have you ever had:

Orthodontic treatment?	YES	NO
Oral surgery?	YES	NO
Periodontal treatment?	YES	NO
Your teeth ground or the bite adjusted?	YES	NO
A bite plate or mouth guard?	YES	NO
A serious injury to the mouth or head?	YES	NO
If yes, please describe, including the cause:		

Do you have an attorney representing you at this time? YES NO

Have you ever experienced:

Clicking or popping of the jaw?	YES	NO
Pain (joint, ear, side of face)?	YES	NO
Difficulty in opening or closing the mouth?	YES	NO
Headaches, neckaches or shoulder aches?	YES	NO
Sore muscles (neck, shoulders)?	YES	NO

Are you satisfied with your teeth's appearance? YES NO

Are you satisfied with your smile?	YES	NO
Would you like to keep all of your teeth all of your life?	YES	NO
Do you feel nervous about having dental treatment?	YES	NO
If yes, what is your biggest concern:		

Have you ever had an upsetting dental experience? YES NO
If yes, please describe: _____

Is there anything else about having dental treatment that you would like us to know? YES NO

If yes, please describe: _____