We strive to provide you with the best possible dental care. To help us serve you better, please fill out this form completely. If you need assistance, please ask – we will be happy to help. You may reach us at 301-662-9133.

1 about you

Today's Date: ______________________________

Email Address: ______________________________

Name: ______________________________

I prefer to be called: ____________________ ❒ Male ❒ Female

Birthdate: ___/____/____ Age: ____ SS#:________________

Home Address: ______________________________

____

Hm#: (____)__________Pager/Celll#: (___)__________

Wk#: (____)__________

Employer: ______________________________

Employer's Address: ______________________________

Occupation: ______________❒Single ❒Married ❒Widow ❒Other

Best times to reach you?______________________________

Whom may we thank for referring you? ________________

Other family members seen by us: ______________________

Previous / Present Dentist: ________________________

Last Visit Date: ______________________________

Do you have a personal physician? ❒Yes ❒No

Physician Name:______________________________

Phone#: (____)__________ Last Visit Date: ______________

Emergency Contact: ______________________________

Relationship: ______________________________

Home#: (____)____________ Work#: (____)____________

Person Responsible for Account: ______________________

Wk#: (____)__________ Ext. ____ Hm#: (____)__________

Billing Address: ______________________________

Relation: ______________ SS#: ______________________

Employer: ____________________ DL#:________________

Last Visit Date: ______________________________

2 spouse information

His / Her Name: ______________________________

Employer: ______________________________

Wk#: (____)__________ Ext.______________________

SS#:______________________________

Birthdate: _____/_____/_____

3 dental insurance

Primary Dental Insurance

Insurance Co. Name: ___________________________

Insurance Co. Address: _________________________

Insurance Co. Phone#: _________________________

ID # (Plan, Local or Policy #): ___________________

Insured's Name: __________Relation: _______________

Insured's Birthdate: ____/____/____ SS#: ____________

Insured's Employer: ______________________________

Secondary Dental Insurance

Insurance Co. Name: ___________________________

Insurance Co. Address: _________________________

Insurance Co. Phone#: _________________________

ID # (Plan, Local or Policy #): ___________________

Insured's Name: _______________ Relation: __________

Insured's Birthdate: ____/____/____ SS#: ____________

Insured's Employer: ______________________________

4 medical history

Your current physical health is: ❒ Good ❒ Fair ❒ Poor

Do you smoke or use tobacco in any form? ❒ Yes ❒ No

Are you taking any prescription / over-the-counter or herbal supplements drugs? ❒ Yes ❒ No

Please list each one: ______________________________

____

Have you, or are you taking medication for osteoporosis? ❒ Yes ❒ No

For Women: Are you taking birth-control pills? ❒ Yes ❒ No

Are you pregnant? ❒ Yes ❒ No Week #: ____________

Are you nursing? ❒ Yes ❒ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Alcohol/ Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Joints
Y N Artificial Heart Valve
Y N Asthma
Y N Blood Transfusion
Y N Cancer/ Chemotherapy
Y N Colitis
Y N Congenital Heart Defects
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/ Fever Blisters
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/ Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any medical conditions that you have ever had:

____

____

Are you allergic to any of the following?

Y N Aspirin
Y N Erythromycin
Y N Penicillin
Y N Codeine
Y N Jewelry / Metals
Y N Tetracycline
Y N Dental Anesthetics
Y N Latex
Y N Other______________________________

____

5 dental history

Why have you come to the dentist today?

____

____

Has your doctor told you that you require antibiotics before dental treatment? ❒ **Yes** ❒ **No**

Are you currently in pain? ❒ Yes ❒ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❒ Yes ❒ No

Do you or have you ever experienced pain / discomfort in your jaw (TMJ / TMD)? ❒ Yes ❒ No

Do you like your smile? ❒ Yes ❒ No

How would you like to improve your smile?

____

Do your gums ever bleed? ❒ Yes ❒ No

How many times a week do you floss? ____________

How many times a day do you brush? ____________

Type of bristles? ❒ Hard ❒ Medium ❒ Soft

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I authorize the dentist to release any information including the diagnostic and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

____

Signature (or parent/guardian, if minor) Date

Payment is due in full at time of treatment unless prior arrangements have been approved. Our office is HIPAA Compliant and committed to meeting or exceeding standards of infection control mandated by OSHA, the CDC, and the ADA.

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