DMV Family Dental
Cosmetic and Preventative Dentistry

McLearen Square Shopping Center | 3065-A Centreville Road | Herndon, VA 20171 | phone 703-437-0333 | fax 703-464-8295

Welcome

ABOUT YOU

Today's Date: _____/_____/_____ Social Security #: _____ Birthdate: _____/_____/_____

Name: _____ Home Phone: _____
Last Name First Name Initial

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Sex: ☐ Male ☐ Female

Email: _____

I am: ☐ Minor (under 18 yrs. old) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer: _____ Business Phone: _____

Business Address: _____ Occupation: _____

May we contact you at your place of work? ☐ Yes ☐ No
If Yes, are we able to leave a detailed message with possible personal information? ☐ Yes ☐ No

Whom may we Thank for referring you? _____

Other family members seen by us: _____

In Case of Emergency, who should we contact? _____

Relation: _____ Phone: _____

SPOUSE INFORMATION

Name: _____ Birthdate: _____/_____/_____ Drivers License #: _____

Email: _____ Cell Phone: _____

Employer: _____ Social Security #: _____

DENTAL HISTORY

Why have you come to see us today? _____

Former Dentist: _____ City: _____ State: _____ Date of Last Dental Visit: _____

How often do you Floss? _____ How often do you Brush? _____

Do you still have wisdom teeth? ☐ Yes, how many _____ ☐ No

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Have you ever experienced problems associated with any previous dental work? ☐ Yes ☐ No

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

Your current health is ☐ Good ☐ Fair ☐ Poor

Do your gums ever bleed? ☐ Yes ☐ No Ever itch? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ **Yes** ☐ **No**
If not, what would you change? _____

Would you like Fresher breath? ☐ Yes ☐ No

Would you like Whiter Teeth? ☐ Yes ☐ No

PLEASE CHECK ALL THAT APPLY:

☐ Bad Breath ☐ Bleeding Gums
☐ Blisters on Lips / Mouth ☐ Finger Nail Biting
☐ Grinding Teeth ☐ Lip / Cheek Biting
☐ Orthodontic Treatment ☐ Pain around Ear
☐ Sensitivity to Cold ☐ Sensitivity to Heat
☐ Sensitivity when Biting ☐ Sensitivity to Sweets
☐ Frequent Headaches ☐ Tooth Pain
☐ Jaw, Head or Neck Injuries
☐ Jaw Difficulty: Clicking and / or Pain
☐ Periodontal Treatment / Disease
☐ Loose Teeth / Broken Fillings

MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Are you currently under medical treatment? ☐ Yes ☐ No

Have you ever had any serious illness or operations in the last 5 years? ☐ Yes ☐ No

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

Do you use alcohol, cocaine or other drugs? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping? ☐ Yes ☐ No

Have you ever taken Fosamax or any Bisphosphonate? ☐ Yes ☐ No

FOR WOMEN ONLY:

Are you taking birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No
If Yes, week #: _____

Are you nursing? ☐ Yes ☐ No

Are you allergic to any of the following? *(Please check all that apply)*

☐ Aspirin ☐ Barbiturates ☐ Codeine
☐ Dental Anesthetics ☐ Erythromycin ☐ Iodine
☐ Jewelry / Metals ☐ Latex ☐ Penicillin
☐ Sedatives ☐ Sulfa Drugs ☐ Tetracycline

Please list additional drugs/ materials that cause you allergic reactions: _____

_____

Current Medications. Because we care about your well-being. Please list all current medications you are using and reason why taking it.

Medication: _____ for: _____ Medication: _____ for: _____
Medication: _____ for: _____ Medication: _____ for: _____
Medication: _____ for: _____ Medication: _____ for: _____
Medication: _____ for: _____ Medication: _____ for: _____

Are you or have you experienced the following? *(Please check all that apply)*

☐ Abnormal Bleeding
☐ AIDS/HIV Positive
☐ Alcohol Abuse
☐ Anemia
☐ Arthritis
☐ Artificial Bones/Joints
☐ Artificial Heart Valves
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Cancer
☐ Chemotherapy
☐ Chicken Pox/Shingles
☐ Colitis
☐ Congenital Heart Disease/ Lesions
☐ Cough: Persistent or bloody
☐ Diabetes
☐ Difficultly Breathing
☐ Drug Abuse
☐ Emphysema
☐ Epilepsy
☐ Fainting or Dizziness
☐ Glaucoma
☐ Hay Fever
☐ Headaches
☐ Heart Attack
☐ Heart Murmur
☐ Heart Problems
☐ Heart Surgery
☐ Hemophilia/Bleeding
☐ Hepatitis _____ Disease
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Jaundice
☐ Kidney Problems/Disease
☐ Liver Problems/Disease
☐ Low Blood Pressure
☐ Lupus
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Osteoporosis/ Paget's Disease
☐ Pacemaker
☐ Psychiatric Treatment
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Shortness of Breath
☐ Sinus Problems
☐ Skin Rash
☐ Steroid Therapy
☐ Stroke
☐ Swelling of Feet/Ankles
☐ Swollen Neck Glands
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis (TB)
☐ Tumor or Growth on Head/ Neck Areas
☐ Ulcers
☐ Venereal Disease
☐ Other: _____

_____

_____

ASSIGNMENT & RELEASE

PAYMENT IS DUE AT TIME OF SERVICE. Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize payment directly to **DMV Family Dental** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider **(DMV Family Dental)** and/or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____