Ashburn General Dentistry

www.ashburngeneraldentistry.com

Patient Information (Confidential)

E-mail Address: _____

Name: _____ Birth Date: _____ Home Phone: _____

Address: _____ Work Phone: _____

City:_____ State: _____ Zip: _____ Cell Phone: _____

Soc. Sec. #_____ Employer: _____ Appt Preference: AM PM

Emergency Contact Name:_____ Their Phone: _____

How would you like to be reminded of your appointment: ❑ E-mail ❑ Text ❑ Cell ❑ Work ❑ Home

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

How did you hear about our office? ❑ Insurance ❑ Newspaper ❑ Mailer ❑ Referral ❑ Magazine ❑ Movie Theatre

Whom may we thank for referring you_____ (They build credit for prizes)

Insurance Company: _____ Subscriber ID #_____ Group #_____

Secondary Ins. Co.: _____ Subscriber ID #_____ Group # _____

Responsible Party: ❑ Self ❑ Other (fill out next 3 line items)

Name of person responsible for this account: _____ Soc. Sec. #_____

Relationship to Patient: _____ Birth Date: _____ Phone # _____

Employer: _____ Is this person currently a patient in our office? ❑ Yes ❑ No

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Please read all notices in the waiting room. Copies of any of these documents will be provided (when requested) including: **Cancellation Policy** and associated fees, our **Notice of Privacy Practices** and Authorization **for release of identifying health information**. Our office is **OSHA, HIPPA** and **Red Flag Rule** compliant. We may show your photos or X-rays to other patients for teaching purposes.

X_____ X_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**

For your convenience, we offer the following methods of payment:
Debit Card • MasterCard • Visa • American Express • Check

Payment is expected at time of service.

We reserve the right to charge a fee for either BROKEN APPOINTMENTS or APPOINTMENTS CANCELLED / CHANGED / RESCHEDULED in less than a 48 Hour period. Ask receptionist for the current fee or see posted sign. Failure to pay the fee may result in the dismissal from the practice and inactivation of your chart. If your account is delinquent, you will be charged an additional 35% to cover collection expenses and a 1.8% monthly finance charge from time of rendered service. Not all procedures are covered by your insurance. If denied by your insurance, you are still responsible.

X_____ X_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**

Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❑ No ❑ Yes, for what: _____
Have you ever been hospitalized or had a major operation? ❑ No ❑ Yes, for what: _____
Have you ever had a serious head or neck injury? ❑ No ❑ Yes, what occurred: _____
Are you taking any medications, pills or drugs? ***❑ No ❑ Yes, which ones:*** _____
Do you take, or have you taken, Phen-Fen or Redux? ❑ No ❑ Yes, for how long: _____
Have you taken Bisphosphonates? ❑ No ❑ Yes, for how long: _____
Are you on a special diet? ❑ No ❑ Yes, which type: _____
Do you use tobacco? ❑ No ❑ Yes, how much daily ____, weekly _____
Do you use any controlled substances? ❑ No ❑ Yes, which ones: _____

Women: Are you… ❑ Pregnant/Trying to get pregnant ❑ Nursing ❑ Taking hormonal contraceptives (oral, patch, other)

Please indicate if you are allergic to any of the following:
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Other:_____

Please indicate if you have, or have you had, any of the following:

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

Have you ever had a serious illness not listed above? ❑ Yes ❑ No ❑ N/A_____
Comments: _____
_____

☐ New 2007 American Heart Association Guidelines do not require prophylactic antibiotics prior to most procedures. Notify us if you have a special situation.
* Condition may require medication. N/A – Not answered by patient

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam: _____

Do your gums bleed while brushing your teeth?	❑ Yes	❑ No	Do you have frequent headaches?	❑ Yes	❑ No
Are your teeth sensitive to hot or cold liquids/foods?	❑ Yes	❑ No	Do you clench or grind your teeth?	❑ Yes	❑ No
Are your teeth sensitive to sweet or sour liquids/foods?	❑ Yes	❑ No	Do you bite your lips or cheeks frequently?	❑ Yes	❑ No
Do you feel pain in any of your teeth?	❑ Yes	❑ No	Have you ever had any difficult extractions?	❑ Yes	❑ No
Do you have any sores or lumps in or near your teeth?	❑ Yes	❑ No	Have you ever had any prolonged bleeding		
Have you had any head neck or jaw injuries?	❑ Yes	❑ No	following extractions?	❑ Yes	❑ No
Have you ever experienced any of the following			Have you had any orthodontic treatment?	❑ Yes	❑ No
problems in your jaw?	❑ Yes	❑ No	Do you wear dentures or partials?	❑ Yes	❑ No
Clicking	❑ Yes	❑ No	If yes, date of placement:_____		
Pain (joint, ear, side of face)	❑ Yes	❑ No	Have you ever received oral hygiene instructions		
Difficulty in opening or closing	❑ Yes	❑ No	regarding the care of your teeth and gums?	❑ Yes	❑ No
Difficulty in chewing	❑ Yes	❑ No	Do you like your smile?	❑ Yes	❑ No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child, during the period of such dental care to third party payors 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 or my dependents.

X_____ **X**_____

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