1990 Old Bridge Rd #301, Woodbridge, VA 22192
(703)491-4040

Patient Information

Name:_____ Birth Date:_____ Age:_____ Sex ❑ M ❑ F

Street address:_____ City:_____ State:_____ Zip: _____

Soc. Sec #:_____ Home Phone:_____ Cell Phone: _____

Work Phone:_____ Email:_____ Marital Status:_____

Employer: _____ Occupation:_____

How did you hear about our practice? _____

Emergency Contact_____ Relation to Patient_____ Phone _____

Responsible Party Information

❑ **Check here for Self**

Name_____ Birth Date _____

Relation to Patient_____ Phone_____ Soc. Sec. # _____

Address (if different from patient's) _____

Employer_____ Occupation_____ Work Phone _____

Insurance Information

Policy Holder's Name_____ Relation to Patient_____ Birth Date _____

Insurance Company Name_____ Policy Holder's Employer's Name: _____

Soc. Sec. #_____ Subscriber #_____ Cell Phone_____

Do you have secondary insurance? ❑ Yes ❑ No

Medical History

Do you have any general health problems? ❑ Yes ❑ No Please specify _____

Are you currently under physician's care? ❑ Yes ❑ No Reason _____

Name and phone of physician _____

Are you currently taking any drugs or medications? ❑ Yes ❑ No Please list _____

_____

Are you allergic to: ❑ Penicillin ❑ Codeine ❑ Latex ❑ Other

Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Check X if you have or have had any of the following:

❑ Anemia
❑ Cortisone Treatments
❑ Hepatitis
❑ Arthritis/Rheumatism
❑ Artificial Heart Valves
❑ Artificial Joints
❑ Asthma
❑ High Blood Pressure
❑ Blood Disorders
❑ Cancer
❑ Chemical Dependency
❑ Chemotherapy
❑ Scarlet Fever
❑ Healing complications
❑ Cortisone Treatments
❑ Diabetes
❑ Epilepsy
❑ Heart Murmur
❑ Heart Problems
❑ HIV/AIDS
❑ Kidney Disease
❑ Liver Disease
❑ Mitral Valve Prolapse
❑ Pacemaker
❑ Prolonged Bleeding
❑ Radiation Treatment
❑ Respiratory Disease
❑ Rheumatic Fever
❑ Shortness of Breath
❑ Stroke
❑ Thyroid Problems
❑ Tuberculosis

Signature Of Patient/Legal Guardian_____ Date _____

Lake Ridge Dental

Dental History

- Are your teeth sensitive to:
  Heat? ❑ Yes ❑ No Cold? ❑ Yes ❑ No Sweets? ❑ Yes ❑ No Biting Pressure? ❑ Yes ❑ No
- Does food constantly get stuck between certain teeth in your mouth? ❑ Yes ❑ No
- Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? ❑ Yes ❑ No
- Are you dissatisfied with your teeth in any way? ❑ Yes ❑ No
- Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc. ❑ Yes ❑ No
- Do you have any fillings that show in your front teeth? ❑ Yes ❑ No
- Do any of your fillings show when you smile? ❑ Yes ❑ No
- If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? ❑ Yes ❑ No
- Have you ever had any teeth removed? ❑ Yes ❑ No
  How long have these teeth been missing? _____
- Do your gums bleed when brushing? ❑ Yes ❑ No
- Do you ever avoid any part of the mouth while brushing? ❑ Yes ❑ No
- Have you been instructed regarding proper home care? ❑ Yes ❑ No
- Do you have an unpleasant taste or odor in your mouth? ❑ Yes ❑ No
- Do you smoke? ❑ Yes ❑ No
- Do you frequently snack between meals on sweets or chew gum? ❑ Yes ❑ No
- How often do you brush your teeth? _____
- Do you use dental floss? ❑ Yes ❑ No
  How often? _____
- Do you want to learn to control dental disease and retain your teeth? ❑ Yes ❑ No
- Has the fear of discomfort kept you from regular dental visits? ❑ Yes ❑ No
- Are you deeply concerned about the finances required to return your mouth to excellent dental health? ❑ Yes ❑ No
- When was your last dental appointment? _____
- What did you have done? _____
- How long since your last thorough examination with full mouth x-rays? _____
- What prompted you to seek dental care at this time? _____
- Why did you leave your last dentist? _____

Remarks

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