viennasmiles
2553 Chain Bridge Road 104
Vienna, VA 22181
t. 703 938 0212 | w. www.viennasmilesva.com

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

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
❑ 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** _____

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Dental History

- What prompted you to seek dental care at this time? _____
- Has the fear of discomfort kept you from regular dental visits?..... ❑ Yes ❑ No
- When was your last dental appointment? _____
- How long since your last thorough examination with full mouth x-rays? _____
- 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
- Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc. ❑ Yes ❑ No
- Do your gums bleed while 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? _____
- How often do you floss?_____

Remarks

_____

_____

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