



8303 Arlington Blvd, Suite: 104
 Fairfax, VA 22031
 t. 703 207 0700 | w. www.mosaicsmiles.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 **If yes please specify same information as above:** _____

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:

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

Signature Of Patient/Legal Guardian _____ Date _____



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Patient: _____

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
