

“Patient Welcome”

● **Date** _____

● **Appointment with Dr.** _____

● **NAME** (last) _____ (first) _____ (MI) _____

Male _____ Female _____

Married ___ Single ___ Other _____

Birth Date _____ - _____ - _____

Social Security # _____ - _____ - _____

Home Address: _____

Street

Apt. #

City

State

Zip Code

E-mail _____

Telephone H- _____ W- _____ Ext. _____

Cell phone _____

Emergency Contact:

Name _____ Relation _____ Tel. _____

Occupation

Employer _____

Employer Address _____

Street

City/State/Zip

Phone

● **Insurance Plan Name** _____

Plan Address _____

Plan Telephone _____

Policy holder SS/ID # _____ Policy holder group # _____

Policyholder name, if other than yourself _____

Policyholder birth date, if other than yourself _____

Is policyholder a patient? Yes _____ No _____

- **Date of last dental visit** _____ reason for visit _____
 Previous dentist _____
 Name ~ address ~ telephone _____

• **Health History** Have you had any of the following? Please check:

- | | | |
|-------------------------|---------------------------|------------------------------------|
| _____ AIDS/HIV | _____ Excessive bleeding | _____ Respiratory problems |
| _____ Allergies | _____ Head injuries | _____ Rheumatic fever |
| _____ Anemia | _____ Heart disease | _____ Rheumatism |
| _____ Arthritis | _____ Heart murmur | _____ Sinus problem |
| _____ Artificial joints | _____ Hepatitis | _____ Stomach problems |
| _____ Asthma | _____ High blood pressure | _____ Stroke |
| _____ Blood disease | _____ Kidney disease | _____ Tuberculosis |
| _____ Cancer | _____ Liver disease | _____ Sexually transmitted disease |
| _____ Diabetes | _____ Mental disorders | _____ CODEINE ALLERGY |
| _____ Dizziness | _____ Pacemaker | _____ PENICILLIN ALLERGY |
| _____ Epilepsy | _____ Radiation treatment | _____ DRUG ALLERGIES |
- Are you pregnant? Yes _____ No _____

Has your doctor told you to take antibiotic medication before dental treatment? _____

- What medications are you currently taking? _____

Have you had complications after dental treatment? Yes _____ No _____

- Explain _____

Have you been admitted to the hospital in the last two years? Yes _____ No _____

- Explain _____

Are you now under care of a physician? Yes _____ No _____

- Explain _____

Physician Name~Address~Telephone _____

Other health problems? Yes _____ No _____

- Explain _____

Would you like to talk with the dentist or hygienist about your smile? Yes _____ No _____

How would you rate your smile on a scale of 1 to 10? _____

Why? _____

Smile topics of interest:

Whitening _____ Bonding _____ Veneers _____ Crowns _____
Straightening _____ Closing spaces _____ Crowding _____
“Complete Smile Makeover” _____

We’d love to thank the person who invited you to our practice!

Another patient....Please write name here: _____

Co-worker.....Please write name here: _____

A dentist.....Please write name here: _____

Our Website.....Please write how you got our web address? _____

Yellow Pages _____

Washingtonian _____

Invisalign _____

Washington Post _____

The sign on our building _____ OTHER _____

- We are a fee-for-service dental practice dedicated to providing comfortable, personalized care at the highest level, in an antiseptic environment.
- It’s our pleasure to help patients file claims for dental benefits—that are **paid to the patient.**
- All fees are due at the time of service.

You or your representative may call me at home or at work to discuss my care or information on this form.

I have read and agree to the above conditions of treatment and payment. To the best of my knowledge, all the above information is correct. I will inform the doctors about any changes in my health.

I _____ have received a copy of this office’s notice of privacy practices.

Signature of patient _____ **Date** _____
(Guardian’s relationship to patient _____)

Please note: A minimum charge is made for failed appointments or those cancelled without 24 hours notice. Thank you.

For your convenience, you may fill out our patient information form prior to your first visit. Please print the form and either bring it with you or fax it to us at 202-467-0690.
