DULLES
LIFE SMILES

Date _____

PATIENT INFORMATION

Name_____ Birthdate _____ SSN_____

Address_____ City _____ State _____ Zip _____

Phone # _____ Cell _____ Email _____

Sex ☐ M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Student

Driver's License # _____

Employer _____ Address _____

Occupation _____ Work Phone Number _____

Emergency contact, Name and Number _____ Relationship _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship _____

Address_____ City _____ State _____ Zip _____

Phone # _____ Cell _____ Email _____

Is this person currently a patient in our office? ☐ YES ☐ NO

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment

☐ Cash ☐ Personal Check ☐ Credit Card ☐ Visa ☐ MasterCard

INSURANCE INFORMATION

Name of insured _____ Relationship _____

Birthdate_____ SSN _____

Insurance Company _____ ID# _____ Group# _____

Insurance Address_____ City _____ State _____ Zip _____

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DENTAL HISTORY

Reason for today's visit _____ Any pain? _____

Former dentist _____ Address _____

Date of most recent cleaning and exam _____ Date of most recent x-ray_____

How often you brush your teeth _____ How often you floss _____

From a scale (0-10) how would you rate your smile? _____

MEDICAL HISTORY

Do you have or you had any of the following? (Please check all that apply to you)

Y	N	Anemia	Y	N	Cortisone treatments/steroids	Y	N	Low blood pressure	Y	N	Skin rash
Y	N	Arthritis, rheumatism	Y	N	Cough, persistent/chronic	Y	N	HIV positive	Y	N	Stroke
Y	N	Artificial heart valves	Y	N	Cough up blood	Y	N	AIDs	Y	N	Congestive heart failure
Y	N	Artificial joints	Y	N	Diabetes	Y	N	Kidney disease	Y	N	Thyroid disease
Y	N	Asthma, sinus problems	Y	N	Epilepsy/seizures	Y	N	Mitral value prolapse	Y	N	Tobacco habit
Y	N	Blood disease	Y	N	Fainting	Y	N	Malignancy or tumor/ cyst	Y	N	Tuberculosis
Y	N	Abnormal bleeding	Y	N	Glaucoma/ eye disorder	Y	N	Nervous disorders	Y	N	Ulcer/ digestive disorder
Y	N	Prolonged healing	Y	N	Headaches, migraine	Y	N	Pacemaker	Y	N	Venereal disease
Y	N	Bruising easily	Y	N	Heart murmur	Y	N	Psychiatric care	Y	N	Swollen neck glands
Y	N	Cancer	Y	N	Heart disease	Y	N	Radiation treatment	Y	N	General allergies
Y	N	Chemical dependency	Y	N	Hemophilia	Y	N	Respiratory disease			
Y	N	Chemotherapy	Y	N	Hepatitis/ liver disease	Y	N	Rheumatic fever/heart disease			
Y	N	Circulatory problems	Y	N	High blood pressure	Y	N	Shortness of breath			

List any medications you are taking now _____

_____

List any medications you are allergic to _____

Signature _____ Date _____

Doctor's Signature _____ Date_____