Bristow
DENTAL CARE

Patient Information

Patient Name: Last: ______________________ First: ______________ Middle Initial: ______

Sex: M F Birthdate: ______________ Age: ____ Soc. Sec.#: ______________________

If Patient is a Minor, Parent or Guardian's Name: ______________________ Marital Status: ______________

Who May We Thank for Referring You to our Office?: ______________________________

Reason for this Visit: ____

Residence Street: ______________ Apt#: ________ City: ____ State: ______ Zip: ________

Mailing Address Street: ______________ Apt#: ________ City: ____ State: ______ Zip: ________

Home Phone: ____________ Cell Phone: ____________ Work Phone: __________ E-mail: ____________

Responsible Party Information

Patient Name: Last: ______________________ First: ______________ Middle Initial: ______

Marital Status: ____

Residence Street: ______________ Apt#: ________ City: ____ State: ______ Zip: ________

Mailing Address Street: ______________ Apt#: ________ City: ____ State: ______ Zip: ________

Home Phone: ____________ Cell Phone: ____________ Work Phone: __________ E-mail: ____________

Dental Insurance Information

Insured's Name: ____

Insurance Co.: ______________________________ Phone: ______________________

Insurance Co. Address: ____

Insured's Employer: ____

Subscriber ID: ______________ Group #: ______________ Date of Birth: ______________

If you have additional dental insurance converge, complete this for the secondary carrier.

Insured's Name: ____

Insurance Co.: ______________________________ Phone: ______________________

Insurance Co. Address: ____

Insured's Employer: ____

Subscriber ID: ______________ Group #: ______________ Date of Birth: ______________

10398 Bristow Center Drive • Bristow, VA 20136 • Phone: (703) 361-0401 • Fax: (703) 361-0403 • www.BristowDental.com

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It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Dental History

How long has it been since you have seen a dentist?: ______________________

Last COMPLETE dental exam, Date: ______________________

Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic):__________

Are you having PROBLEMS now?	Yes	No
WHAT? ______________________		
Is your present dental health POOR?	Yes	No
Do you wear DENTURES? (Partials or Full)	Yes	No
Are you UNHAPPY with your dentures?	Yes	No
Would you like to know more about PERMANENT REPLACEMENTS?	Yes	No
Are you APPREHENSIVE about dental treatment?	Yes	No
Have you had any PERIODONTAL (GUM) treatments?	Yes	No
Do you gums BLEED, or feel TENDER or IRRITATED?	Yes	No
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	Yes	No
Are you UNHAPPY with the APPEARANCE of your teeth?	Yes	No
Are you aware of GRINDING or CLENCHING your teeth?	Yes	No
Do you have HEADACHES, EARACHES, or NECK PAIN?	Yes	No
Have you worn BRACES on your teeth (ORTHODONTICS)?	Yes	No
Do you have DISCOLORED teeth that bother you?	Yes	No
Would you like your smile to LOOK BETTER or DIFFERENT?	Yes	No
Do you REGULARLY use DENTAL FLOSS?	Yes	No
Do you have any CURRENT HEALTH PROBLEMS?	Yes	No
Are you under a PHYSICIANS'S CARE now? If yes for what?	Yes	No
Have you ever taken Fen-Phen___ Redux___ Coumadin___	Yes	No
What MEDICATIONS are you currently taking?: ______________		
Do you need to premedicate?	Yes	No
Are you PREGNANT?	Yes	No
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	Yes	No

Name of Previous Dentist: ______________________

Address: ______________________

City: ______________________ State:________

Medical History

Please √ yes or no of the following which yo9u have had, or presently have:

AIDS/HIV Pos.	Yes	No	Hepatitis	Yes	No
Anaphylaxis	Yes	No	High blood pressure	Yes	No
Anemia	Yes	No	Jaw pain	Yes	No
Arthritis (Rheumatism)	Yes	No	Kidney disease or malfunction	Yes	No
Artificial Heart Valve	Yes	No	Liver disease	Yes	No
Artificial Joints	Yes	No	Material allergies	Yes	No
Asthma	Yes	No	(latex, wood, metal, chemicals)	Yes	No
Seasonal Allergies	Yes	No	Mitral valve prolapse	Yes	No
Back Problems	Yes	No	Multiple Sclerosis	Yes	No
Blood Disease	Yes	No	Nervous problems	Yes	No
Cancer	Yes	No	Pacemaker/heart surgery	Yes	No
Chemical dependency	Yes	No	Psychiatric care	Yes	No
Chemotherapy	Yes	No	Rapid weight gain/loss	Yes	No
Circulatory problems	Yes	No	Radiation treatment	Yes	No
Cortisone treatments	Yes	No	Respiratory disease	Yes	No
Cough (persistent)	Yes	No	Rheumatic/scarlet fever	Yes	No
Cough up blood	Yes	No	Shingles	Yes	No
Diabetes	Yes	No	Shortness of breath	Yes	No
Epilepsy	Yes	No	Skin rash	Yes	No
Fainting	Yes	No	Spina Bifida	Yes	No
Food allergies	Yes	No	Stroke	Yes	No
Glaucoma	Yes	No	Surgical implants	Yes	No
Headaches	Yes	No	Swelling of feet or ankles	Yes	No
Heart murmur	Yes	No	Thyroid disease or malfunction	Yes	No
Heart Problems	Yes	No	Tobacco habit	Yes	No
Please describe:			Tonsillitis Yes	No	
______________________			Tuberculosis	Yes	No
Hemophilia	Yes	No	Ulcer/Colitis	Yes	No
Herpes	Yes	No	Venereal disease	Yes	No

Are you allergic or have you reacted adversely to any of the following?

Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves etc.)

Nitrous Oxide Codeine Penicillin

Are you allergic to any other medication or substances?

If yes, list:

Is there other Medical or Dental information that you feel we should know of?

Family Physiscan: ____________ Phone:___________ E-mail:___________

To the best of my knowledge, the above is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I and/or my dependants(s), have insurance coverage with ________________ and assign directly to Dr.________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Patient Signature (Parent of Child)________________________ Date_______ Signature of Dentist______________

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