Village Dentistry of Leesburg

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Patient Name:_____ Date of Birth:_____/_____/_____ Age:_____
Last First MI

1. ABOUT PATIENT

Gender: ☐ Male ☐ Female SS#:_____/_____/_____

_____
Home address

_____
City State Zip

_____ _____
Home phone Cell phone

_____
Email address

Status: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer:_____ How long?_____

_____
Work phone Occupation

_____
Employer's City State Zip

2. ACCOUNT INFO

Person ultimately responsible for account other than Patient:

☐ Parent/Guardian ☐ Spouse ☐ _____

Gender: ☐ Male ☐ Female SS#:_____/_____/_____

_____
Last Name First MI

_____ _____/_____/_____
Contact Phone Date of Birth

_____
Billing address (if different from home address)

_____
Billing City State Zip

3. EMERGENCY CONTACT

_____
Last Name First MI

Relation: ☐ Spouse ☐ Parent/Guardian ☐ _____

_____ _____
Phone (Home / Work) Cell Phone

_____-_____
Primary Physician name & phone number

4. DENTAL HEALTH

Reasons for today's visit?
☐ Consultation ☐ Exam ☐ Emergency ☐ Treatment

Are you in Pain? ☐ Yes ☐ No If yes, how long? _____
Last time were seen by a dentist?
_____

_____ _____
Doctor's name Phone number

_____
Doctor's location

Was treatment recommended? ☐ Yes ☐ No
Was treatment completed? ☐ Yes ☐ No
Last date you had X-rays? _____

_____
How often do you brush? Floss?_____
Have you ever had your teeth straightened? ☐ Yes ☐ No
If yes, when? _____

Do you use electric or manual toothbrush? _____
Do you require pre-medication before treatment?
☐ Yes ☐ No ☐ Do not know
Are you allergic to Anesthetics?
☐ Yes ☐ No ☐ Do not know
Are you happy with the appearance of your teeth/ smile?
☐ Yes ☐ No
Do you want your teeth to last a lifetime?
☐ Yes ☐ No
Please choose from the following:

☐ Bad breath even after brushing
☐ Broken / Chipped tooth
☐ Broken or lost filling
☐ Burning sensation on tongue
☐ Chew on one side
☐ Clicking or popping jaw
☐ Dry Mouth
☐ Finger/ Nail Biting
☐ Food collection between teeth
☐ Grind or Clench
☐ Jaw pain or tiredness
☐ Locking jaw
☐ Lip or cheek biting
☐ Pain or discomfort around ear
☐ Periodontal treatment
☐ Red, swollen or bleeding gum
☐ Ringing in ears
☐ Sensitive tooth to hot or cold
☐ Sores or growth in mouth
☐ Stained teeth
☐ Vertigo
☐ Other:

5. REFERRAL SOURCE

Whom may we thank for referring you to our practice?

Another Patient:_____
Relationship: ☐Family ☐Friend ☐Neighbor ☐Colleague

Other:
☐ Walk-in ☐ Local newspaper ☐Mailing ☐Facebook
☐Google ☐Bing/Yahoo ☐Chamber of Commerce
☐Insurance directory
other: _____

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HEALTH QUESTIANIARE

Patient Name:_____Date of Birth:_____/_____/_____Age:_____
Last First MI

Are you allergic to any of the following?
☐ Penicillin Family ☐Latex ☐Tetracycline ☐ Aspirin ☐Anesthetics ☐ Nuts ☐ Do not know_____

Do you use tobacco or smoke? ☐Yes ☐ No how often?_____ Have you ever taken drug Phen-fen or Redux? ☐ Yes ☐ No
Are you taking any medications? ☐ Yes ☐ No
If yes, what type of medications? ☐ Nerve Pills ☐ Pain Killers ☐ Insulin ☐ Muscle Relaxers ☐Tranquilizers ☐ Blood Thinners
☐ Stimulants Other _____
_____
_____

Name of medications:
Have you had any surgery in the past 3 years? ☐ Yes ☐ No If yes, when and explain?

Are you under the care of a physician for an illness? ☐Yes ☐ No
If yes, name of physician and phone #
Have you ever had or have any of the following? Please check all that apply

☐ Anaphylaxis	☐ Excessive Bleeding	☐ Pacemaker
☐ AIDS / HIV Positive	☐ Fainting / Spells / Dizziness	☐ Radiation or Chemotherapy
☐ Allergies	☐ Glaucoma	☐ Respiratory Problems
☐ Anemia	☐ Hay Fever	☐ Rheumatic fever
☐ Arthritis / Gout	☐ Head Injuries	☐ Rheumatism
☐ Artificial Joints	☐ Headaches Migraines	☐ Sinus Problems
☐ Artificial Heart Valve	☐ Heart Disease	☐ Stomach Problems
☐ Asthma	☐ Heart Murmur	☐ Stroke
☐ Back and/or Neck problems	☐ Hepatitis: Type☐ A ☐ B ☐ C	☐ Thyroid
☐ Blood Disease: _____	☐ Hemophilia	☐ Tuberculosis
☐ Blood Pressure: High Low	☐ Kidney Disease:	☐ Tumors or Growths
☐ Cancer:_____	☐ Liver Disease / Jaundice	☐ Ulcers / H-Pylori Positive
☐ Diabetes	☐ Mental Disorder	☐ Venereal Disease
☐ Epilepsy or Seizures	☐ Nervous Disorders	☐ Other: _____

For women: Are you pregnant? ☐ Yes ☐ No If yes, due date: _____
If no, are you taking birth control pills? ☐ Yes ☐ No

I guarantee this form was completed correctly to the best of my knowledge, and understand that it is my responsibility to inform this office of any changes to my contact numbers, address information, email address, and any changes to my health or prescriptions. I also read, understand and agree to the office policy.

_____ Date:_____/_____/_____

Signature of: Patient Parent/Guardian Other:

Your First Visit

Your initial first visit involves getting to know you, the problem you are experiencing and your dental needs. If you do not have any up to date copies of your dental records and X-Ray from your previous dentist; we will be taking a full mouth X-Rays to have an overview of your oral health.

After your initial appointment and reviewing your X-Rays, a treatment plan will be initiated for your consultation visit. This will give you an idea of what type of treatment you may need, the cost, and any insurance coverage.