Welcome

Lnt Dental
5288 Dawes Ave
Alexandria, VA 22311
Ph: (703) 595 – 2345
Lntdental1@gmail.com

1. Patient Information *(confidential)*

First Name:_____Last Name:_____ Middel Initial:_____Today's Date: _____

SS #:_____Birth Date:_____Age:_____Drivers Lic:_____State:_____

Address: _____City: _____State: _____Zip:_____

Home Phone:_____Work:_____Cell:_____Email:_____

Sex: Male/Female **Marital Status**: Married / Single / Divorced / Widowed / Separated **Student Status**: Full /Part Time

Emloyer:_____Occupation:_____Employment Status: _____

Employer's Address:_____City:_____State:_____Zip:_____

Referred by: _____

2. Emergency Contact

Emergencey Contact # 1: _____Relation to Patient: _____Phone #:_____

Emergency Contact # 2: _____Relation to Patient: _____Phone #: _____

Address: _____City: _____State: _____Zip: _____

Primary Care Physician: _____Physician's Phone #: _____

3. Responsible Party

Self_____ Spouse_____Parent_____ If not self please complete the following:

Name of Responsible party: _____SS#: _____Relationship to Patient: _____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work:_____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.

CASH_____ CARE CREDIT_____VISA_____ MC_____ DIS._____ AMEX____ I wish to discuss the office's payment policy____

4. Insurance Information

Name of Insured: _____SS #: _____Relationship to Patient: _____

Insurance Co. Name: _____ Group #: _____ Policy #: _____

Insurance Co. Address: _____ City: _____ State: _____Zip: _____

Insurance Phone #:_____

Do you have additional Dental Insurance? NO_____YES _____if yes complete the following:

Insurance Co. Name: _____Group #: _____Policy #: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Insurance Phone #: _____

5. Dental Information

Reason for today's visit: Exam _____ Cleaning _____ Consultation _____ Emergency _____

Other: _____

Are you in pain? _____ NO _____ YES If yes, How Long _____

Previous Dentist Name: _____ Office Location: _____ Date of last exam: _____

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold liquids/foods? Yes No
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes No
4. Do you feel pain to any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you ever experience any of the following problems in your jaw?
   - Clicking Yes No
   - Pain (joint, ear, side of face) Yes No
   - Difficulty in opening or closing Yes No
   - Difficulty in chewing Yes No
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
10. Do you bite your lips or cheeks frequently? Yes No
11. Have you ever had any difficult extractions in the past? Yes No
12. Have you ever had any prolonged bleeding following extractions? Yes No
13. Have you had any orthodontic treatment? Yes No
14. Have you had any orthodontic treatment? Yes No
15. Do you wear dentures or partials? Yes No
    If yes, date of placement ----------
16. Have you ever received oral hygience instruction regarding the care of your teeth & gums Yes No

6. Health Information

1. CIRCLE APPROPRIATE ANSWER *(leave BLANK if you do not understand question):*

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years? If YES, why?
4. Yes No Are you being treated by a physician now? For what?_____ Date of last medical exam?_____ Phone Number: _____

2. HAVE YOU EXPERIENCED:

5. Yes No Chest pain (angina)?
6. Yes No Swollen ankles?
7. Yes No Shortness of breath?
8. Yes No Recent weight loss, fever, night sweats?
9. Yes No Persistent cough, coughing up blood?
10. Yes No Bleeding problems, bruising easily?
11. Yes No Sinus problems?
12. Yes No Difficulty swallowing?
13. Yes No Diarrhea, constipation, blood in stools?
14. Yes No Frequent vomiting, nausea?
15. Yes No Difficulty urinating, blood in urine?
16. Yes No Dizziness?
17. Yes No Ringing in ears?
18. Yes No Headaches?
19. Yes No Fainting spells?
20. Yes No Blurred vision?
21. Yes No Seizures?
22. Yes No Excessive thirst?
23. Yes No Frequent urination?
24. Yes No Dry mouth?
25. Yes No Jaundice?
26. Yes No Joint pain, stiffness?

3. DO YOU HAVE OR HAVE YOU HAD:

27.	Yes	No	Heart disease?	38.	Yes	No	AIDS
28.	Yes	No	Heart attack, heart defects?	39.	Yes	No	Tumors, cancer?
29.	Yes	No	Heart murmurs?	40.	Yes	No	Arthritis, rheumatism?
30.	Yes	No	Rheumatic fever?	41.	Yes	No	Eye diseases?
31.	Yes	No	Stroke, hardening of arteries?	42.	Yes	No	Skin diseases?
32.	Yes	No	High blood pressure?	43.	Yes	No	Anemia?
33.	Yes	No	Asthma, TB, emphysema, other lung diseases?	44.	Yes	No	VD (syphilis or gonorrhea)?
34.	Yes	No	Hepatitis, other liver disease?	45.	Yes	No	Herpes?
35.	Yes	No	Stomach problems, ulcers?	46.	Yes	No	Kidney, bladder disease?
36.	Yes	No	Allergies to: drugs, foods, medications, latex?	47.	Yes	No	Thyroid, adrenal disease?
37.	Yes	No	Family history of diabetes, heart problems?	48.	Yes	No	Diabetes?

4. DO YOU HAVE OR HAVE YOU HAD:

49.	Yes	No	Psychiatric care?	54.	Yes	No	Hospitalization?
50.	Yes	No	Radiation treatments?	55.	Yes	No	Blood transfusions?
51.	Yes	No	Chemotherapy?	56.	Yes	No	Surgeries?
52.	Yes	No	Prosthetic heart valve?	57.	Yes	No	Pacemaker?
53.	Yes	No	Artificial joint?	58.	Yes	No	Contact lenses?

5. ARE YOU TAKING:

59.	Yes	No	Recreational drugs?	61.	Yes	No	Tobacco in any form?
60.	Yes	No	Drugs, medications, over-the-counter (including Apirin), natural remedies?	62.	Yes	No	Alcohol?

Please list:_____

_____

6. WOMEN ONLY:

63. Yes No Are you or could you be pregnant or nursing? 64. Yes No Taking birth control

7. ALL PATIENTS:

65. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____

_____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____/_____/_____

Signature for patient (or parent / guardian if minor) **Date**