Chevy Chase Dental Center

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Chart#:

FOR OFFICE USE ONLY

Patient Name: Last First MI

Preferred Name

Title: **Gender:** Mr/Ms/Mrs/etc ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:

SS#: ___-__-____

Prev. Visit:

Email Address:

Best time to call:

Phone: Home Mobile Work Ext

Fax Other

Address: Address 1

Address 2

City State Zip Code

Preferred method of confirmations:

☐ Call ☐ Email ☐ Text

How did you hear about us?

Please select:

◯ A patient - Please write name below:
◯ Dentist/Physician - Please write name below:
◯ Internet
◯ Angie's List
◯ Google
◯ Our Website
◯ Yellow Pages
◯ Insurance

In an emergency who should be notified? Please enter Name and Phone number below:

Employer

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____

Phone: _____

Employer Address: _____
Address 1

_____
Address 2

_____
City

_____ _____-____
State Zip Code

Dental Insurance:

Name of Insured: _____
Last

_____ ___
First MI

Insured's Birth Date: _____

ID #: **Group #:** _____

_____

Insured's Address: _____
Address 1

_____
Address 2

_____
City

_____ _____-____
State Zip Code

Insured's Employer Name:

_____

Employer Address: _____
Address 1

_____
Address 2

_____
City

_____ _____-____
State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

_____

Insurance Address:

_____
Address 1

_____
Address 2

_____
City

_____ _____-____
State Zip Code

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Medicate
- ☐ Allergies
- ☐ Allergy - Other
- ☐ Anemia
- ☐ Anxiety Disorders
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Aspirin Allergy
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chron's Disease
- ☐ Codeine Allergy
- ☐ Coumadin
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Erythromycin Allergy
- ☐ Excessive Bleeding
- ☐ Extreme Fear Dentist
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes or Cold Sores
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Lupus
- ☐ Meds (See Pt. Notes)
- ☐ Mental Disorders
- ☐ Mitra Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Nervous Disorders
- ☐ No Epi
- ☐ Obstr Sleep Apnea
- ☐ Other- See Pt. Notes
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Penicillin Allergy
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seasonal allergy
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Snoring
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Sulfa Allergy
- ☐ Tetracycline Allergy
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

- ☐ Ever been hospitalized (illness or injury)
- ☐ Presently being treated for any other illnesses
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Taking dietary supplements
- ☐ Subject to frequent headaches
- ☐ A smoker or smoked previously
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and your most recent physical exam:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

_____

_____

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

_____

_____

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of most recent dental exam: _____

Date of most recent dental x-rays: _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

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

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

Topics of Interest:

☐ Smile Makeover ☐ Gummy smile ☐ Bonding ☐ Veneers/Crowns ☐ Invisalign Invisible Braces

☐ Crowding/closing spaces ☐ Implants ☐ Whitening

Is there anything you'd like us to know to make your visit as comfortable as possibe? ◯ Yes ◯ No

If yes, please let us know:

If any of the checked boxes need further explanation, please describe:

Name of patient, parent or guardian completing this form: *

Relationship to patient: *

Response Date: _____