2 Cardinal Park Drive, Suite 204A Leesburg, VA 20175
ashton@leesburgfamilydental.com
(703) 779-2296

Date:_______________________

PATIENT INFORMATION: Please enter information for the PATIENT ONLY in this section.

Name:______________________________ Birth Date:________________ Cell Phone:______________________

Sex: ☐ M ☐ F Status: ☐ Married ☐ Single ☐ Minor

Address:__________________________________ City:________________ State:_____ Zip Code:__________

Home Phone: (___)________________ Work Phone(____)______________ Email:______________________

Whom may we thank for referring you?____

Emergency Contact:_________________________________ Emergency Contact Phone: (_____)____________

RESPONSIBLE PARTY: Please enter info for the PERSON RESPONSIBLE FOR PAYMENT OF SERVICES OR IS THE SUBSCRIBER OF THE INSURANCE. Please Note: If the patient is a minor (under age 18), the adult and/or guardian accompanying the patient to any treatment visit is responsible for payment of services.

Relationship to Patient: Self / Spouse / Parent / Other_____________________ Cell Phone:(____)______________

Name:________________________ Gender: ☐ M ☐ F Social Security #_____-_____-_____ DOB:___________

Address:______________________________ City:________________ State:__________ Zip Code:__________

Drivers License #:____________________ Employer:______________________ Work Phone:( )____________

DENTAL HISTORY:

Reason for today's visit/any concerns:____

Former Dentist:________________________________ Former Dentist Phone:________________________

Date of last dental visit :_____________________________ Date of last dental xrays:_____________________

How often do you floss?_____________________________ How often do you brush?______________________

Check if you have had any problems with the following:

☐ Bad breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food collection between teeth
☐ Grinding teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in your mouth

Are you happy with the appearance of your smile? Yes No Somewhat

Is there anything you don't like about your teeth?____

____

MEDICAL HISTORY:

Physician's Name:____________________ Physician's Phone:(_____)_________Date of last Visit:______________

Have you ever used a bisphosphonate medication? Common Brand Name: Fosamax, Actonel, Atelvia, Didronel, Boniva.
☐ Yes ☐ No

Have you ever needed to pre-medicate with antibiotics before a dental visit/treatment? ☐ Yes ☐ No

Are you taking any blood thinners? ☐ Yes ☐ No

Allergies or reactions to: Antibiotics / Pain Medicines / Local Anesthetics / Latex / Other:________________________

____

Please list any prescriptions or over the counter medications you are currently taking:__________________________

____

Have you ever been hospitalized for any surgery or serious
illness?____

If Female: Are you taking hormones or birth control? ☐ Yes ☐ No
Are you pregnant or nursing ☐ Yes ☐ No Is there a possibility that you may be pregnant? ☐ Yes ☐ No

Please mark on "Ye s" or "No" to indicate if you have had any of the following:

Yes	No	
☐	☐	Anemia
☐	☐	Arthritis, Rheumatism
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joints, Pins
☐	☐	Asthma
☐	☐	Back Problem
☐	☐	Bleeding abnormally
☐	☐	Blood Disease
☐	☐	Cancer
☐	☐	Chemical Dependency
☐	☐	Chemotherapy
☐	☐	Circulatory Problems
☐	☐	Congenital Heart Lesions

Yes	No	
☐	☐	Cortisone Treatments
☐	☐	Cough Persistent
☐	☐	Cough up Blood
☐	☐	COVID 19
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Fainting
☐	☐	Glaucoma
☐	☐	Headaches
☐	☐	Heart Murmur
☐	☐	Heart Problems
☐	☐	Hemophilia
☐	☐	Hepatitis

Yes	No	
☐	☐	Hernia Repair
☐	☐	High Blood Pressure
☐	☐	HIV/AIDS
☐	☐	Jaw Pain
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Mitral Valve Prolaspe
☐	☐	Pacemaker
☐	☐	Radiation Treatment
☐	☐	Respiratory Disease
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Shortness of Breath

Yes	No	
☐	☐	Skin Rash
☐	☐	Stroke
☐	☐	Swelling of Feet/Ankle
☐	☐	Thyroid Problems
☐	☐	Tobacco Habit
☐	☐	Tonsillitis
☐	☐	Tuberculosis
☐	☐	Ulcer
☐	☐	Venereal Disease
☐	☐	Osteoporosis treatment

AUTHORIZATION AND RELEASE:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a health change.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________and assign directly to Cardinal Park Family Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Cardinal Park Family Dental Care may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or in one year from the date signed below.

____ ______________________________
Signature of Patient, Parent, Guardian or Personal Representative Date

____ ______________________________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient