PATIENT INFORMATION

Welcome to Downtown Family Dental of Leesburg

To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name _____ Preferred name _____

Date of Birth_____ Social Security number: _____

If minor, parents' names _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Minor

Mailing address _____ City _____State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

E-Mail Address _____

Employer _____ Occupation _____

Spouse's name & phone #_____ Spouse's employer_____

Emergency Contact name & phone # _____

How did you hear about our office? ❑ I am a previous patient of Dr. Pham/Dr. Groy ❑ Website ❑ Facebook

❑ Newspaper ❑ Insurance Website ❑ Dental Flyer ❑ Yorktown Flyer ❑ Google ❑ Other: _____

❑ Friend - If you were referred by a friend, whom may we thank? _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (Please check any that apply)

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Bones
- ❑ Artificial Heart
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Bisphosphonates
- ❑ Blood Transfusion
- ❑ Cancer
  Type: _____
- ❑ Congenital Heart Defect
- ❑ Diabetes
  Type: _____
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack (Yr____)
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hepatitis Type: ____
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ HIV / AIDS
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Do you smoke or use chewing tobacco? ❑ Yes ❑ No

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

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Metals
- ❑ Tetracycline
- ❑ Other:_____

Please list your medications or provide us with a list to copy:

_____
_____
_____
_____
_____
_____
_____

Women:

- ❑ Are you pregnant or may be pregnant?
  Estimated # of weeks: _____
- ❑ Are you nursing?
- ❑ Are you taking birth control?

❑ Do you require **antibiotic prophylaxis** prior to treatment?
If yes, for what reason?

Name & Phone Number of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

Dental History

Reason for today's visit _____
Former Dentist _____
City/State _____
Date of last dental visit _____

Do you experience any of the following?
Please check any that apply

- ❑ Bad Breath
- ❑ Bleeding gums
- ❑ Blisters on lips or mouth
- ❑ Burning sensation on tongue
- ❑ Chew on one side of mouth
- ❑ Cigarette, pipe, or cigar smoking
- ❑ Clicking or popping jaw
- ❑ Dry mouth
- ❑ Fingernail biting
- ❑ Food collection between teeth
- ❑ Foreign objects
- ❑ Grinding teeth
- ❑ Gums swollen or tender
- ❑ Jaw pain or tiredness
- ❑ Lip or cheek biting
- ❑ Loose teeth or broken fillings
- ❑ Mouth breathing
- ❑ Mouth pain, brushing
- ❑ Orthodontic treatment
- ❑ Pain around ear
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

DENTAL INSURANCE INFORMATION: ❑ **Not covered by dental insurance**

Subscriber _____ Employer_____
Insurance company _____ Group number _____
Subscriber's ID#_____ Date of Birth_____

Are you covered by a secondary dental insurance? ❑ Yes ❑ No
Subscriber _____ Employer_____
Insurance company _____ Group number _____
Subscriber's ID#_____ Date of Birth_____

Guarantor Information (Person responsible for account or insurance)

Guarantor's Name _____ Social Security Number: _____
Employer Name _____Address _____
City _____ State_____ Date of Birth _____ Phone# _____

As a courtesy to our patients, we will submit insurance claims on your behalf. Please understand that all fees are estimated based on information provided by the insurance, NOT A GUARANTEE of payment by them. In the event that the insurance company does not pay their estimated portion, the patient will be responsible for that amount.

Initial _____ I authorize my dental insurance company to pay (assignment of benefits) to the office of Downtown Family Dental of Leesburg.

Signature of Patient (or Parent/Guardian) _____ Date _____