Dulles Dental Group

Welcome To Our Office

Today's Date_____

Patient's Name_____ DOB:_____

Spouse or Parent (If Patient is a minor)_____ DOB:_____

SS No._____ ❍ Male ❍ Female ❍ Single ❍ Married

HomeAddress_____Apt#_____City_____Zip_____

Phone:_____ Cell:_____ E-Mail Address_____

Method of contact: Email ❍Yes ❍No Text ❍Yes ❍No Phone ❍Yes ❍No

Whom can we thank for referring you?_____

Responsible Party/Insurance

Insurance Subscriber Name_____ D.O.B_____ S.S #:_____

Dental Insurance Carrier_____ Member #:_____ Group#:_____

Insurance Phone#:_____ Employer_____

Emergency contact name and phone_____

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DENTAL HISTORY

What is the main reason for your visit today? _____

When was your last dental exam? _____ Previous Dentist's name:_____

What was your reason for transferring? _____

What did you like most/least about your former dental office?_____

How often do you?

1. Have dental exams and cleaning? _____
2. Brush your teeth? _____
3. Floss your teeth? _____

Are your teeth sensitive to:

Hot, cold, sweets? ❍ Yes ❍ No

Biting or Chewing ❍ Yes ❍ No

Do your gums bleed or hurt: ❍ Yes ❍ No

Do you have a history of gum disease in your family? ❍ Yes ❍ No

Does food tend to get caught between your teeth? ❍ Yes ❍ No

Have you ever had:

Orthodontic treatment? ❍ Yes ❍ No

Jaw surgery? ❍ Yes ❍ No

Periodontal treatment? ❍ Yes ❍ No

Have you ever experienced:

Clicking or popping of your jaw? ❍ Yes ❍ No

Do you clench or grind your teeth? ❍ Yes ❍ No

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U P D A T E
Medical History

Patient's Name _____Physician's Name_____

1. Are you under any medical treatment? ❍ Yes ❍ No
   A. Have you been hospitalized in the last 2 years? ❍ Yes ❍ No
   B. Have you had any serious illness in your lifetime? ❍ Yes ❍ No
   Explain:_____
2. Are you currently taking **prescription medications** and for what: ❍ Yes ❍ No
   Please list: _____
   _____
3. Do you have any allergies? List:_____ ❍ Yes ❍ No
4. Have you had any **allergic reactions** to drugs or anesthetic? ❍ Yes ❍ No
   Penicillin ____ Aspirin ____Codeine ____Sulfa ____Novocain ____Other _____
5. Have you taken corticosteroids or blood thinners including aspirin recently? ❍ Yes ❍ No
   Which and for how long? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING

__ Heart murmur, Mitral valve prolapse
__ Heart attack When:_____
__ Heart Surgery When:_____
__Heart Disease
__ Artificial heart valve or joints
Pre. Med: _____
__ Blood pressure High: __ Low__
__ Cholesterol High: __ Low__
__ Hemophilia
__ Blood transfusion
__Autoimmune diseases
__ Rheumatic fever
__ Diabetes Type 1:__ Type2:__
__ Hepatitis A:__ B:__ C:__

__ Thyroid problems
__ Tuberculosis
__ Liver disease
__ HIV/Aids
__ Epilepsy/Seizures
__ Kidney disease
__ Ulcers or Intestinal disorders
__ Venereal disease
__Asthma , Emphysema, Respiratory disease
__ Arthritis or Rheumatism
__ Chemo or Radiation therapy
__ Tumors or Growths
__ Latex sensitivity
__ Drug or Alcohol abuse
__ Nervousness/Anxiety

Have you ever had any swelling or serious injury to the mouth, head or neck area? ❍ Yes ❍ No
Do you use tobacco products? ❍ Yes ❍ No
Women: Are you: pregnant _____nursing _____ taking birth control _____
NOTES:_____

I understand the above information is necessary in to provide safe, effective dental care. I have answered the questions to the best of my knowledge. I understand I am responsible for all cost of dental treatment. I authorize this office to administer such medications and perform such diagnostic/therapeutic procedures as may be necessary.

Signature: _____ Date:_____

DULLES DENTAL GROUP
5103 Westfields Boulevard
Centreville, VA 20120
Phone: 703-802-8999
Fax: 703-802-4704

FINANCIAL &CANCELATION POLICY

Charges for services rendered are due and payable the day of the appointment.

1. **We will assist with filing insurance; however, the Patient, Parent, or Guardian is directly responsible for payment in full of any and all fees not paid for by the insurance company. There are no exceptions or discounts. When treatment *co-pays* are quoted by the office, these are estimates only, your actual insurance coverage may be less or more.**

2. **Appointment cancellations with less than 24 hours' notice are subject to a fee of $55.00 for Hygiene appointments and $85 for appointment scheduled for 1 hour and $125 for appointment over an hour.**

3. **Amalgams (silver fillings) are no longer used at this office. Most insurance companies do not pay full benefits due to exclusions in individual policies for composite (tooth colored) fillings. The patient, parent or guardian is liable for all additional costs.**

4. Payment plans are available upon prior arrangements. Please speak to the office manager prior to treatment.

5. Personal checks that are returned due to "insufficient funds" are subject to a $65 service fee.

I have read and understand the Financial Policy of Dulles Dental Group. I acknowledge and agree to the above terms and reaffirm these terms each time I receive treatment for myself or my dependents. I agree to be responsible for all dental services and materials not paid by my dental insurance for me or my dependents. I authorize release of any information relating to any insurance claims to the relevant insurance company. I authorize payment of dental insurance benefits to Dulles Dental Group, unless payable to me directly per the Insurance Plan.

Signature of Patient/Parent/Guardian if Minor:

_____ Date: _____
Signature

_____
Print Name

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