

# WASHINGTON METRO DENTAL NEW PATIENT PAPERWORK

Revised: March 3, 2021

Washington Metro Dental

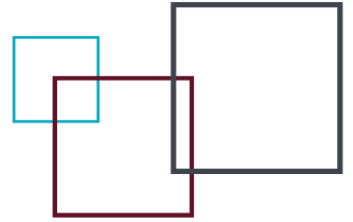
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**ABOUT YOU**

*Name*

*Today's Date*

\_\_\_\_\_

\_\_\_\_\_

*Date of Birth*

*Social Security Number*

\_\_\_\_\_

\_\_\_\_\_

*Address*

\_\_\_\_\_

\_\_\_\_\_

*Mobile Phone*

*Home Phone*

*Work Phone*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Email*

*Occupation*

\_\_\_\_\_

\_\_\_\_\_

*Emergency Contact*

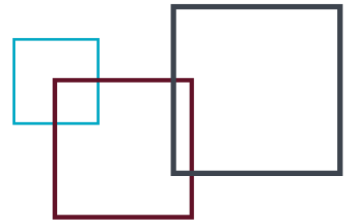
*Emergency Contact Phone*

\_\_\_\_\_

\_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR OFFICE? CHECK ALL THAT APPLY.**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Family Member | <input type="checkbox"/> Friend                  | <input type="checkbox"/> Colleague      | <input type="checkbox"/> Other Dental Office |
| <input type="checkbox"/> Facebook Post | <input type="checkbox"/> Facebook Ad             | <input type="checkbox"/> Instagram Post | <input type="checkbox"/> Instagram Ad        |
| <input type="checkbox"/> Google Ad     | <input type="checkbox"/> General Internet Search | <input type="checkbox"/> ZocDoc         | <input type="checkbox"/> Post Card/Mail      |
| <input type="checkbox"/> Other: _____  |  |   |  |



DENTAL INFORMATION:

Please mark each box with your response, use 'DK' if you do not know an answer.

Table of dental questions with Yes/No/DK columns. Questions include: Are you currently experiencing any pain or discomfort? Do your gums bleed when you brush or floss? Are your teeth sensitive to cold, hot, sweets or pressure? Is your mouth dry? Have you had any periodontal (gum) treatments? Have you ever had orthodontic (braces) treatment? Have you had any problems associated with previous dental treatment? Do you have earaches or neck pain? Do you have any clicking, popping or discomfort in the jaw? Do you brux (grind) your teeth? Do you have sores or ulcers in your mouth? Do you wear dentures or partials? Do you participate in active recreational activities? Have you ever had a serious injury to your head or mouth?

What was the date of your last dental exam (month and year)?

What is the reason for your visit today?

How do you feel about your smile?

Do you have dental insurance? If so, please provide the details below. Please also provide your card so we may make a copy.

Insurance Carrier ID Number Group Number

Subscriber Name Subscriber Birthday

MEDICAL INFORMATION:

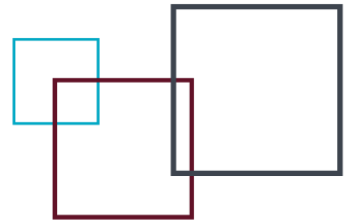
Please mark each box with your response, use 'DK' if you do not know an answer.

Are you under the care of a physician?

Physician Name: Physician Phone Number:

Have you had a serious illness, operation or have been hospitalized in the past 5 years? Yes No DK

If yes, what was the problem:



Yes No DK

**Joint Replacement:** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: \_\_\_\_\_

If yes, have you had any complications? \_\_\_\_\_

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease?

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Date Treatment began: \_\_\_\_\_

**Allergies:** Are you allergic to or have you had a reaction to:

Local anesthetics

Aspirin

Penicillin or other antibiotics

Barbituates, sedatives or sleeping pills

Sulfa drugs

Codeine or other narcotics

Metals

Yes No DK

Latex (rubber)

Iodine

Hay fever/seasonal

Animals

Food

Other: \_\_\_\_\_

Do you use controlled substances (drugs)?

Do you use tobacco (smoking, snuff, chew, bidis)?

If so, how interested are you in stopping?

Very  Somewhat  Not Interested

Do you drink alcoholic beverages?

If yes, how much alcohol did you drink in the last 24 hours: \_\_\_\_\_

If yes, how much do you typically drink in a week? \_\_\_\_\_

**WOMEN ONLY:** Are you:

Pregnant?

Number of weeks: \_\_\_\_\_

Taking birth control pills or hormonal replacement?

Nursing?

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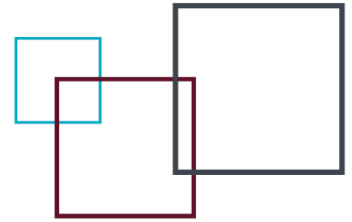
Yes No DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of the physician or dentist making the recommendation: \_\_\_\_\_ Phone Number: \_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

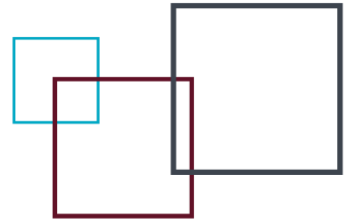
\_\_\_\_\_



**MEDICAL INFORMATION:**

Please mark each box with your response to indicate if you have or have not had any of the following diseases or problems

	Yes	No	DK		Yes	No	DK
Artificial (prosthetic) heart valve .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/Radiation treatment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease (CHD) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GE Reflux/persistent heart burn .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify: _____			
Rheumatic fever .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you snore? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify: _____			
Blood transfusion .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date: _____				Type of infections: _____			
Hemophilia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/migraines .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systematic lupus erythematosus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				



*Please list any other disease, condition or problem not listed about that you think we should know about?*

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Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information give on this form is accurate. I understand the importance of a truthful health history and that my dentist and the staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff, responsible for any action they take or do not take because of errors or omissions that I may have made I the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_

Date: