WASHINGTON METRO DENTAL NEW PATIENT PAPERWORK

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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.

- ❑ Family Member
- ❑ Facebook Post
- ❑ Google Ad
- ❑ Other: _____
- ❑ Friend
- ❑ Facebook Ad
- ❑ General Internet Search
- ❑ Colleague
- ❑ Instagram Post
- ❑ ZocDoc
- ❑ Other Dental Office
- ❑ Instagram Ad
- ❑ Post Card/Mail

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DENTAL INFORMATION:

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

	Yes	No	DK
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?	☐	☐	☐

	Yes	No	DK
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:* _____

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

If yes, what was the problem: _____

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	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:

	Yes	No	DK
Local anesthetics	□	□	□
Aspirin	□	□	□
Penicillin or other antibiotics	□	□	□
Barbituates, sedatives or sleeping pills	□	□	□
Sulfa drugs	□	□	□
Codeine or other narcotics	□	□	□
Metals	□	□	□
Latex (rubber)	□	□	□
Iodine	□	□	□
Hay fever/seasonal	□	□	□
Animals	□	□	□
Food	□	□	□

Other: _____

	Yes	No	DK
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?	□	□	□

	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:

_____

_____

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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
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital Heart Disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV Infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systematic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐

	Yes	No	DK
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/Radiation treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
GE Reflux/persistent heart burn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify: _____			
Recurrent infections	☐	☐	☐
Type of infections: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

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

_____

_____

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: