## *Welcome to Central Virginia Family Dentistry*

**Today's Date**____/____/____

Patient Name_____
Last First MI

Nickname_____ ☐Male ☐Female

Birthdate____/____/____ Age_____ SS#_____

Mailing Address_____

_____
City State Zip Code

Home Phone# _____ Cell Phone#_____

Work Phone#_____ Ext_____ Referred By_____

Email for Notifications_____

Occupation_____ Employer_____

Status ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name_____ Children ☐Yes ☐No How many_____

In Case of Emergency Contact_____

Relation_____ Phone #( )_____

Your Medical Doctor_____ Phone #( )_____

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**Primary Dental Insurance Company**_____

Subscriber's Name_____ Date of Birth____/____/____

Relationship to Patient_____ Subscriber's Employer_____

Ins Company Address_____
City State Zip

Ins Company Phone#_____

Member ID #_____ Group #_____

**Secondary Dental Insurance Company**_____

Subscriber's Name_____ Date of Birth____/____/____

Relationship to Patient_____ Subscriber's Employer_____

Ins Company Address_____
City State Zip

Ins Company Phone # ( )_____

Member ID #_____ Group #_____

**Over Please ☛**

## Dental Information

Reason for visit: ☐Exam ☐Emergency ☐Consultation Are you in pain: ☐No ☐Yes How long?_____

Previous Dentist_____ Phone#_____

Last Exam_____/_____/_____ Last X-rays_____/_____/_____

Times a day you brush_____ Times a day you floss_____

## Indicate the following problems

☐Discomfort, clicking, popping, or locking jaw ☐Lost/broken filling(s) ☐Stained teeth ☐Teeth grinding

☐Red, swollen, or bleeding gums ☐Sensitive tooth, teeth, or gums ☐Bad breath ☐Ringing in ears

☐Broken/chipped tooth ☐Blister/sores in or around mouth ☐Other_____

## Medical Information

Are you allergic to: ☐Latex ☐Penicillin/Amoxicillin ☐Tetracycline ☐Aspirin ☐Dental Anesthetics

☐ Food_____ ☐Other:_____

**Do you require antibiotic pre-medication** ☐Yes ☐No ☐Unsure

**Have you ever taken:** ☐Bisphosphonate (ex. Aredia/Fosamax)

**Current medications** ☐Nerve pills ☐Pain killers ☐ Aspirin ☐Muscle Relaxers ☐Stimulants ☐Blood Thinners

☐Tranquilizers ☐Insulin ☐Medication for Osteoporosis ☐Others, please list_____

_____

## Please check Yes or No - PLEASE DO NOT LEAVE UNMARKED

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ☐Yes ☐No | Alcohol Abuse | ☐Yes ☐No | Hay Fever | ☐Yes ☐No | Sickle Cell |
| ☐Yes ☐No | Allergies (seasonal) | ☐Yes ☐No | Heart Attack | ☐Yes ☐No | Sinus Problems |
| ☐Yes ☐No | Anemia | ☐Yes ☐No | Heart Murmur | ☐Yes ☐No | Stroke |
| ☐Yes ☐No | Arthritis | ☐Yes ☐No | Heart Surgery | ☐Yes ☐No | Taken Phen-fen/Redux |
| ☐Yes ☐No | Artificial Heart Valves | ☐Yes ☐No | Hepatitis A | ☐Yes ☐No | Taking Blood Thinners |
| ☐Yes ☐No | Artificial Joint | ☐Yes ☐No | Hepatitis B | ☐Yes ☐No | Thyroid Problems |
| ☐Yes ☐No | Asthma | ☐Yes ☐No | High Blood Pressure | ☐Yes ☐No | Tuberculosis |
| ☐Yes ☐No | Bleeding Problems | ☐Yes ☐No | Jaw Problems | ☐Yes ☐No | Stomach Ulcers/Problems |
| ☐Yes ☐No | Chemo/Cancer _____ | ☐Yes ☐No | Kidney Problem | ☐Yes ☐No | Venereal Disease |
| ☐Yes ☐No | Chest Pains | ☐Yes ☐No | Knee Replacement | ☐Yes ☐No | Heart Disease |
| ☐Yes ☐No | Congenital Heart Defect | ☐Yes ☐No | Liver Disease | ☐Yes ☐No | Scarlet Fever |
| ☐Yes ☐No | Diabetes | ☐Yes ☐No | Low Blood Pressure | ☐Yes ☐No | Respiratory Problems |
| ☐Yes ☐No | Difficulty Breathing | ☐Yes ☐No | Mitral Valve Prolapse | ☐Yes ☐No | Hepatitis C |
| ☐Yes ☐No | Drug Abuse | ☐Yes ☐No | Nervousness | ☐Yes ☐No | Emphysema |
| ☐Yes ☐No | Epilepsy | ☐Yes ☐No | Pace Maker | ☐Yes ☐No | Neck Pain/Back Problems |
| ☐Yes ☐No | Fainting | ☐Yes ☐No | Pre-medication | ☐Yes ☐No | Cosmetic Surgery |
| ☐Yes ☐No | Fever Blisters | ☐Yes ☐No | Psychiatric History | ☐Yes ☐No | X-ray/Cobalt Treatment |
| ☐Yes ☐No | Head Aches | ☐Yes ☐No | Rheumatic Fever | ☐Yes ☐No | Hypoglycemia |
| ☐Yes ☐No | Glaucoma | ☐Yes ☐No | Seizures | ☐Yes ☐No | Leukemia |
| ☐Yes ☐No | HIV/AIDS | ☐Yes ☐No | Shingles | ☐Yes ☐No | Bone Cancer |

Please list any surgeries or medical conditions: _____

_____

**Do you use tobacco ☐No ☐Yes How used_____ How much_____ How long_____**

**Woman:** Are you taking Birth Control pills ☐No ☐Yes How many children have you had_____

Are you currently pregnant? ☐No ☐Yes/Weeks_____

Are you currently nursing? ☐No ☐Yes

❖I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

**Signature**_____ Date_____

☐Adult Patient ☐Parent/Guardian ☐Spouse