Central Virginia Family Dentistry

Today's Date: _____/_____/_____

Patient Name: _____

Preferred Name: _____ ○ Male ○ Female

Birthdate: _____/_____/_____ Age: _____ SS#: _____

Mailing Address: _____

_____

City State Zip

Home Phone: _____ Cell Phone: _____

Email:_____

Occupation: _____ Employer: _____

Status: ○ Minor ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Spouse's Name: _____ Children: ○ Yes ○ No How many? _____

Emergency Contact: _____ Phone Number: _____

Do you have a primary care physician? ○ Yes ○ No Name:_____

Please make sure you provide the front desk receptionist with you Dental Insurance card and information!

***If you are not the policy holder, please provide the following information:**

Policy Holder: _____ Date of Birth: _____/_____/_____

Address (if different): _____

Dental Information

Reason for Visit: ○ Exam ○ Emergency ○ Consultation

Are you in pain? ○ Yes ○ No How long? _____

Previous Dentist: _____ Last Exam/X-rays: _____

Medical Information

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

Food allergies: _____ Other: _____

Over Please →

Do you require antibiotic pre-medication? ○ Yes ○ No ○ Unsure

Have you ever taken? ○ Bisphosphonate (ex. Aredia/Fosamax)

Current medications: _____

_____

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	Shingles
○Yes○No	Anemia	○Yes○No	Heart Murmur	○Yes○No	Stroke
○Yes○No	Arthritis	○Yes○No	Heart Surgery	○Yes○No	Taken Phen-fed/ Redux
○Yes○No	Artificial Heart Valves	○Yes○No	Hepatitis A		
○Yes○No	Artificial Joint	○Yes○No	Hepatitis B	○Yes○No	Taking Blood Thinners
○Yes○No	Asthma	○Yes○No	High Blood Pressure		
○Yes○No	Bleeding Problems	○Yes○No	Jaw Problems	○Yes○No	Thyroid Problems
○Yes○No	Chemo/Cancer _____	○Yes○No	Kidney Problem	○Yes○No	Tuberculosis
		○Yes○No	Knee Replacement	○Yes○No	Stomach Ulcers
○Yes○No	Chest Pains	○Yes○No	Liver Disease	○Yes○No	Venereal Disease
○Yes○No	Congenital Heart Defect	○Yes○No	Low Blood Pressure	○Yes○No	Heart Disease
		○Yes○No	Migraine	○Yes○No	Scarlet Fever
○Yes○No	Diabetes	○Yes○No	Mitral Valve Prolapse	○Yes○No	Respiratory Problems
○Yes○No	Difficulty Breathing	○Yes○No	Nervousness	○Yes○No	Hepatitis C
○Yes○No	Drug Abuse	○Yes○No	Pacemaker	○Yes○No	Emphysema
○Yes○No	Epilepsy	○Yes○No	Psychiatric History	○Yes○No	Neck/Back Pain
○Yes○No	Fainting	○Yes○No	Rheumatic Fever	○Yes○No	Cosmetic Surgery
○Yes○No	Fever Blisters	○Yes○No	Seizures	○Yes○No	X-ray/Cobalt Treatment
○Yes○No	Headaches	○Yes○No	Shingles		
○Yes○No	Glaucoma			○Yes○No	Hypogylcemia
○Yes○No	HIV/AIDS			○Yes○No	Leukemia
				○Yes○No	Bone Cancer

Please list any surgeries or medical conditions: _____

_____

Do you use tobacco? ○ Yes ○ No How used: _____ How much: _____ How long: _____

Women: Are you taking birth control pills? ○ Yes ○ No

Are you currently pregnant or nursing? ○ Yes ○ No

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: _____/_____/_____