WELCOME

Patient Information (Confidential) Date ____________________

Name ____________________________ Birthdate ________________ SS#_ ________________________
(copy of driver's license if no ss# given)

Home Phone ______________________ Cell Phone _________________

Email ______________________________________ May we confirm your appointment via email? _______

Address _______________________________________ City ___________________ State __________ Zip ________

Check appropriate status: Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated ___

Patient's or Patient/Guardian Employer ____________________________ Work Phone ______________________

Business Address _________________________________ City __________________ State _______ Zip _________

Spouse or Parent's Name ____________________ Employer __________________ Work Phone _______________

If Patient is a Student, Name of School/College ____________________ City __________________ State ________

Whom May we Thank for Referring you? ____

Emergency Contact ____ Phone ___________________________

Responsible Party

Person Responsible for this Account ______________________ Relationship to Patient ______________________

Address ____ Home Phone __________________

SS# _______________________ Birthdate _________________ Employer ____________________________________

Work Phone _______________________ Is this person currently a patient in our office? __________

Insurance Information (Please provide Insurance Card)

Name of Insured _______________________________________ Relationship to Patient _______________

Birthdate ___________________ SS# _________________________ Home Phone ________________________

Name of Employer ______________________________________ Work Phone ________________

Address of Employer ____ City _____________ State ____ Zip _______

Insurance Company ____________________________ ID# ____________________ Group # __________________

MEDICAL HISTORY

Patient Name ______ Nickname ______ Age ______
Name of Physician/and their specialty ______
Most recent physical examination ______ Purpose ______
What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. hospitalization for illness or injury ______ ☐ ☐
2. an allergic reaction to ______ ☐ ☐
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ metals (nickel, gold, silver, ______)
   - ☐ latex
   - ☐ other ______
3. heart problems, or cardiac stent within the last six months ______ ☐ ☐
4. history of infective endocarditis ______ ☐ ☐
5. artificial heart valve, repaired heart defect (PFO) ______ ☐ ☐
6. pacemaker or implantable defibrillator ______ ☐ ☐
7. orthopedic implant (joint replacement) ______ ☐ ☐
8. rheumatic or scarlet fever ______ ☐ ☐
9. high or low blood pressure ______ ☐ ☐
10. a stroke (taking blood thinners) ______ ☐ ☐
11. anemia or other blood disorder ______ ☐ ☐
12. prolonged bleeding due to a slight cut (INR > 3.5) ______ ☐ ☐
13. emphysema, shortness of breath, sarcoidosis ______ ☐ ☐
14. tuberculosis, measles, chicken pox ______ ☐ ☐
15. asthma ______ ☐ ☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) ☐ ☐
17. kidney disease ______ ☐ ☐
18. liver disease ______ ☐ ☐
19. jaundice ______ ☐ ☐
20. thyroid, parathyroid disease, or calcium deficiency ______ ☐ ☐
21. hormone deficiency ______ ☐ ☐
22. high cholesterol or taking statin drugs ______ ☐ ☐
23. diabetes (HbA1c = ______) ______ ☐ ☐
24. stomach or duodenal ulcer ______ ☐ ☐
25. digestive disorders (i.e. celiac disease, gastric reflux) ______ ☐ ☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ______ ☐ ☐

YES NO

27. arthritis ______ ☐ ☐
28. autoimmune disease ______ ☐ ☐
    (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ______ ☐ ☐
30. contact lenses ______ ☐ ☐
31. head or neck injuries ______ ☐ ☐
32. epilepsy, convulsions (seizures) ______ ☐ ☐
33. neurologic disorders (ADD/ADHD, prion disease) ______ ☐ ☐
34. viral infections and cold sores ______ ☐ ☐
35. any lumps or swelling in the mouth ______ ☐ ☐
36. hives, skin rash, hay fever ______ ☐ ☐
37. STI / STD / HPV ______ ☐ ☐
38. hepatitis (type ___) ______ ☐ ☐
39. HIV / AIDS ______ ☐ ☐
40. tumor, abnormal growth ______ ☐ ☐
41. radiation therapy ______ ☐ ☐
42. chemotherapy, immunosuppressive medication ______ ☐ ☐
43. emotional difficulties ______ ☐ ☐
44. psychiatric treatment ______ ☐ ☐
45. antidepressant medication ______ ☐ ☐
46. alcohol / recreational drug use ______ ☐ ☐

ARE YOU:

47. presently being treated for any other illness ______ ☐ ☐
48. aware of a change in your health in the last 24 hours
    (i.e. fever, chills, new cough, or diarrhea) ______ ☐ ☐
49. taking medication for weight management ______ ☐ ☐
50. taking dietary supplements ______ ☐ ☐
51. often exhausted or fatigued ______ ☐ ☐
52. experiencing frequent headaches ______ ☐ ☐
53. a smoker, smoked previously or use smokeless tobacco ______ ☐ ☐
54. considered a touchy / sensitive person ______ ☐ ☐
55. often unhappy or depressed ______ ☐ ☐
56. taking birth control pills ______ ☐ ☐
57. currently pregnant ______ ☐ ☐
58. prostate disorders ______ ☐ ☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

______

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______ Date ______
Doctor's Signature ______ Date ______

ASA ______ **(1-6)** ◯ ◯ ◯

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DENTAL HISTORY

Name________________________________ Nickname________________________________ Age__________

Referred by____________________________How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _________________________________How long have you been a patient?____________Months/Years ☐

Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______

Date of most recent treatment (other than a cleaning) ______/______/______

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

#	Question	YES	NO
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] ______________	☐	☐
2.	Have you had an unfavorable dental experience? ______________	☐	☐
3.	Have you ever had complications from past dental treatment? ______________	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic? ______________	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted? ______________	☐	☐
6.	Have you had any teeth removed or missing teeth that never developed? ______________	☐	☐

GUM AND BONE

#	Question	YES	NO
7.	Do your gums bleed or are they painful when brushing or flossing? ______________	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? ______________	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth? ______________	☐	☐
10.	Is there anyone with a history of periodontal disease in your family? ______________	☐	☐
11.	Have you ever experienced gum recession? ______________	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ______________	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth? ______________	☐	☐

TOOTH STRUCTURE

#	Question	YES	NO
14.	Have you had any cavities within the past 3 years? ______________	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ______________	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ______________	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ______________	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line? ______________	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ______________	☐	☐
20.	Do you frequently get food caught between any teeth? ______________	☐	☐

BITE AND JAW JOINT

#	Question	YES	NO
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______________	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you bite your teeth together? ______________	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ______________	☐	☐
24.	Have your teeth changed in the last 5 years, become shorter, thinner or worn? ______________	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped? ______________	☐	☐
26.	Are your teeth developing spaces or becoming more loose? ______________	☐	☐
27.	Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? ______________	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue? ______________	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ______________	☐	☐
30.	Do you clench your teeth in the daytime or make them sore? ______________	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? ______________	☐	☐
32.	Do you wear or have you ever worn a bite appliance? ______________	☐	☐

SMILE CHARACTERISTICS

#	Question	YES	NO
33.	Is there anything about the appearance of your teeth that you would like to change? ______________	☐	☐
34.	Have you ever whitened (bleached) your teeth? ______________	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth? ______________	☐	☐
36.	Have you been disappointed with the appearance of previous dental work? ______________	☐	☐

Patient's Signature ____ Date______________

Doctor's Signature ____ Date______________

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Mt. Vernon Center for Dentistry

Cosmetic and Restorative Dentistry

FINANCIAL AGREEMENT

At our practice, we believe that you deserve the best care, as well as a clear understanding of your financial responsibilities in achieving that care. We provide dental services to many patients. Some have dental benefits, but some do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know...

We currently accept all private care insurance plans, (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we will work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.**

We submit your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Ultimately, you are responsible for all charges incurred in our office.

We require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash and checks (for existing patients with established payment history). If you are in need of a financial option, we also work with Care Credit, who offers short term and extended term financing options designed to meet your treatment plan needs with approved credit. Just ask us for a brochure or apply online at www.carecredit.com.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 48 hour** notice to avoid a **$150 cancellation fee** (true emergencies are an exception).

We welcome you to our practice and look forward to working in partnership with you to achieve and maintain a healthy, beautiful smile. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our team members.

Print: ______________________________

Sign: ______________________________

Date: ______________________________

Approved by: ________________________

MT. VERNON

Center For Dentistry

Dental Photography Release

I, __________ (please print), hereby authorize the team at Mount Vernon Center for Dentistry to take photographs, slides, and/or videos of my face, jaw, mouth, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, will benefit my diagnosis, treatment planning, laboratory communications and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I acknowledge Mount Vernon Center for Dentistry's right to crop of otherwise treat the photographs at their discretion. I also acknowledge that Mount Vernon Center for Dentistry may choose to show my photographs and testimonials through the office website and/or other marketing channels. I acknowledge that the images can be downloaded by any computer user, which is beyond the control of Mount Vernon Center for Dentistry and I will hold them and any of their affiliated office harmless from such use or download.

I do not expect compensation, financial or otherwise, for the use of these photographs.

I hereby freely and voluntarily consent to the use of my photographs and testimonials as stated above until I revoke this consent in writing.

Print Name ______________________________

Signature________________________________

Name of Guardian (if minor)__________________

Date____________________________________

MT. VERNON CENTER FOR DENTISTRY
8101 Hinson Farm Road, Suite 114
Alexandria, Virginia 22306
(703) 360-5881

ACKNOWLEDGEMENT
OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** ***You May Refuse to Sign this Acknowledgement*** ***

I, ______________________________, have received a copy of this office's Notice of
(Print Patient Name)

Privacy Practices.

____
(Patient Signature)

____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barrier prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify)

____

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