



Patient Registration

Date _____

First Name _____ Last Name _____ M.I. ____ Preferred Name _____
Social Security Number _____ Birth Date _____ Sex: [] Male [] Female
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ E-mail _____
Family Status: [] Minor [] Single [] Married [] Divorced [] Widowed [] Separated
If college student, full time / part time, name of school _____ City _____ State _____
Patient's or Parent's/Guardian's Employer _____ Work phone _____
Work Address _____ City _____ State _____ Zip _____
Spouse or Parent's/Guardian's Name _____ Employer _____ Work Phone _____
Person to contact in case of emergency _____ Phone _____

Responsible Party Information

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
Social Security Number _____ Birth Date _____ Driver's License Number _____
Employer _____ Work Phone _____
Is this person a current patient in our office? [] Yes [] No

Insurance Information

Name of Insured _____ Relationship to patient _____
Birth Date _____ Social Security Number _____ Date Employed _____
Name of Employer _____ Work Phone _____
Work Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone _____ Group # _____ Policy/I.D. # _____
Insurance Co. Address _____ City _____ State _____ Zip _____

Do You Have Additional Dental Insurance? [] Yes [] No If yes, complete the following:

Name of Insured _____ Relationship to patient _____
Birth Date _____ Social Security Number _____ Date Employed _____
Name of Employer _____ Work Phone _____
Work Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone _____ Group # _____ Policy/I.D. # _____
Insurance Co. Address _____ City _____ State _____ Zip _____

Referral Information

Whom may we thank for referring you to our practice? [] Another patient, friend [] Another patient, relative
[] Internet / Website [] Newspaper Ad [] Radio Ad [] Yellow Pages [] Insurance Plan
[] Other _____ Name of person referring you to our practice _____

Please complete Medical History Form on next page.



Medical History

Patient's Name _____ Date of Birth _____

Please check the box for any condition that you have now or have had at any time in the past.

Have you seen a physician for a medical condition in the last 6 months? [] Yes [] No
If so when and why? _____
Physician's name and phone number _____

Have you had an operation, illness or been hospitalized in the last five years? [] Yes [] No
If so when and why? _____

Have you ever been instructed to pre-medicate with antibiotics prior to dental treatment for any health related condition such as a Heart Murmur, Artificial Joints, Rheumatic fever etc? [] Yes [] No

Women: Are you? [] Pregnant, if so, how many weeks? _____ [] Nursing [] Taking Birth Control Pills

Cardiovascular (Heart)

- [] High Blood Pressure
[] Heart Attack
[] Angina/Chest Pain
[] Damaged Heart Valves
[] Heart Murmur
[] Mitral Valve Prolapse
[] Rheumatic Fever
[] Congenital Heart Defect
[] Irregular Heartbeat
[] Pacemaker
[] Heart Surgery
[] Other Heart Problems

Skin/Musculoskeletal

- [] Latex allergy
[] Arthritis
[] Artificial Joint
[] Back or neck problems

Nerves & Sensory

- [] Epilepsy / Seizures
[] Fainting / Dizziness
[] Nervousness
[] Numbness or Tingling

Respiratory (Breathing)

- [] Bronchitis / Chronic Cough
[] Sinus Problems
[] Allergies or Hives
[] Asthma
[] Tuberculosis (TB)

Endocrine (Hormones)

- [] Diabetes
[] Thyroid Disease

Hematologic (Blood)

- [] Stroke
[] Anemia
[] Prolonged Bleeding
[] Take Blood Thinners
[] HIV / AIDS Positive

Gastrointestinal (Digestive)

- [] Gastric Reflux
[] Gastric Bypass Surgery
[] Stomach Ulcers
[] Liver Disease
[] Hepatitis

Urinary

- [] Kidney Problems

Other Conditions

- [] Mental Health Problems
[] Eye Disease / Glaucoma
[] Cancer / Tumors
[] Radiation / Chemotherapy
[] Use Tobacco
[] Alcohol Abuse
[] Drug Abuse / Dependency
[] Excessive Snoring
[] Cortisone Treatment

Please list any other medical conditions or concerns not mentioned above that the doctor should be aware of _____

Are you taking, or supposed to be taking, any medication? Please include all prescription and non-prescription drugs as well as any herbal supplements _____

Are you allergic to any drugs or medicines? [] Yes [] No If so, what drug and what type of reaction did you have? _____

Do you wish to speak to the doctor privately about anything? _____

Please complete Dental History Form on next page



Purcellville DENTAL

Dental History

Patient's Name _____ Birth Date _____

Reason for today's visit _____

When was your last dental visit? _____ What was done then? _____

How often did you visit the dentist before then? _____

Have you had a **complete series** of dental x-rays taken? Yes No If so, when? _____

How often do you brush your teeth? _____ How often do you floss? _____

Is your drinking water fluoridated? _____ City water or well water? _____

Please answer all of the following questions by checking the appropriate box:

Do you feel pain in any area of your mouth? Yes No
If so, where and when? _____

How long has this been a problem? _____

Do you have any sores, lumps or bumps in or around your mouth? Yes No

Are your teeth sensitive to hot or cold? Yes No

Are your teeth sensitive to sweets? Yes No

Are any of your teeth missing? Yes No

If so, are you interested in replacement options? Yes No

Do you wear full or partial dentures? Yes No

Do you have difficulty chewing due to missing teeth or poorly fitting replacements Yes No

Do you have any broken teeth? Yes No

Have you ever been told you have periodontal disease (gum disease)? Yes No

Have you ever had treatment for periodontal disease? Yes No

Do your gums bleed while brushing or flossing? Yes No

Do you have any loose teeth? Yes No

Do you have areas where food gets caught? Yes No

Do you have concerns about bad breath? Yes No

Have you had any of the following jaw problems?

Clicking or popping Yes No

Pain in jaw joint, ear or side of face Yes No

Difficulty opening wide Yes No

Jaw locking open Yes No

Do you have frequent headaches? Yes No

Do you clench or grind your teeth? Yes No

Have you ever had treatment for "TMJ"? Yes No

Do you or have you ever worn a night guard or bite plate? Yes No

Have you had any head, neck or jaw injuries? Yes No

Have you ever had prolonged bleeding after extractions or any other dental treatment? Yes No

Have you had bad experiences with past dental treatment? Yes No

Has fear or anxiety kept you from receiving needed dental treatment? Yes No

Are you unhappy with the appearance of your teeth or smile? Yes No

Have you ever had your teeth bleached? Yes No

Have you ever had your teeth restored for cosmetic purposes? Yes No

Are you interested in options to change or improve the appearance of your teeth? Yes No

If you could change anything about the appearance of your smile, what would you change? _____

Please discuss any additional dental concerns that you may have: _____

Authorization and Release

Please read and initial each line then sign below:

_____ I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health care providers.

_____ I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. In such case, I understand that I am responsible for my portion of payment at the time of service. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that this office reserves the right to refuse to accept payment from my insurance company and that, in such case, I am responsible for payment at the time of service unless prior financial arrangements have been made.

_____ I authorize Timothy A. Smith, D.D.S. and his staff to take radiographs (x-rays), models, photographs or any other diagnostic aids deemed necessary by the doctor to make a thorough diagnosis of my, or my dependents dental needs. Furthermore, I authorize Timothy A. Smith, D.D.S. and his staff to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the above named patient.

_____ I understand and authorize the use of any of my photographs, radiographs or models for educational, demonstrational or promotional purposes.

_____ I understand there will be a \$35 service fee on returned checks.

_____ I understand that all appointments are reserved in advance. Confirmation of appointments is required. Failure to show for an appointment or cancellations with less than 24 hours notice may result in a missed appointment fee. Multiple missed appointments will result in my dismissal from this practice.

Signature of patient, parent or guardian: _____ Date: _____ Relationship to patient: _____