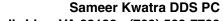


## Sameer Kwatra DDS PC & A S S O C I A T E S 2970 Prince William Parkway • Woodbridge, VA 22192 - (703) 583-7720

Patient information	rorm	Today's Date
Patient Name: First	MI Last	Nickname
Address: Street	City	State Zip
Phone: Home	Work	Mobile
E-mail address		
By Providing your e-mail address you agree	e to receive (check one or both) □ Appointme	ent Reminders 🗆 Practice Newsletter
What is your preferred method of contact?	☐ Home Phone ☐ Work Phone ☐ Mobile	e Phone □ E-Mail
Social Security Number	Date of Birth	
Drivers License #	State	
Patient Employed By	Occupation	Phone
Address: Street	City	State Zip
Sex □ Male □ Female Marital Status	□ Married □ Single □ Divorced □ Sep	parated D Widowed
In case of emergency, who should be notified	ed?	
Relationship to Patient	Home Phone	Mobile Phone
If patient is a Minor, primary residency  Address: (if different from patient) Street	Both Parents	State Zip
		Mobile
Employer (if different from above)	Occupation	Phone
Address: Street	City	State Zip
Dental Benefit Plan Information	on	
Primary Dental Plan Name		Phone
Address: Street	City	State Zip
Name of Insured	Date of Birth	ID Number
Policy Number	Patient Relationship to Insured_	
Secondary Dental Plan Name		Phone
Address: Street	City	State Zip
Name of Insured	Date of Birth	ID Number
Policy Number	Patient Relationship to Insured_	







Patient Signature (Parent if child)

Patient's Name: **DENTAL HISTORY** Yes No Yes No Please check any of the following problems If you could whiten your teeth for a cost that apply to you. anyone could afford, would you do it? -Sensitivity (hot; cold, sweet, pressure) Do you smoke or use chewing tobacco? Where? UR LR UL LL How much? For how long?  $\Box$ -Headaches, earaches, neck pain If I could change my smile, I would: -Jaw joint pain -Make it whiter -Teeth or fillings breaking -Make it straighter -Grinding or clenching teeth -Close spaces -Bleeding, swollen or irritated gums -Replace black metal fillings with tooth -Loose, tipped or shifting teeth colored restorations П -Bad breath -Repair chipped teeth Do you have or have you had any of the following? -Replace missing teeth -Dentures -Replace old crowns that don't match -Partial dentures -Have a smile makeover -Braces ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING: -Periodontal (gum) treatments How important is your dental health to you? Please share the following dates: 2 3 4 5 10 1 - Your last cleaning Where would you rate your current dental health? - Your last oral cancer screening 2 10 1 3 4 5 6 - Your last complete X-Rays Where do you want your dental health to be? Name of Previous Dentist 2 3 4 5 6 10 Why did you leave your previous dentist? City Phone Number \_ What is the most important thing to you about your future smile and dental health? What is the most important thing to you about your dental visit today? **MEDICAL HISTORY** Please check any of the following problems/conditions that apply to you: YES YES NO YES NO NO YES NO **AIDS** Dizziness **HIV** Positive Scarlet Fever П П П П П Allergies (Seasonal) **Drug Addiction** HPV (Human Papilloma Virus) □ Seizures  $\Box$ Anemia Emphysema Jaundice Sinus Problems Angina (Chest pain) **Epilepsy** Jaw Joint Pain Sleep Apnea Arthritis **Excessive Bleeding** Kidney Disease Stomach Problems П П Artificial Heart Valve Fainting Liver Disease Stroke П П **Artificial Joints** Glaucoma Low Blood Pressure Thyroid Disease П Tuberculosis **Heart Conditions** П Asthma Mitral Valve Prolapse Nervousness/Depression □ Heart Lesions (Congenital) □ Ulcers **Blood Disease** Bruise Easily Heart Murmur Pacemaker Venereal Diseases Cancer П **Heart Surgery** П Pregnant Currently Other Radiation (head/neck) Cervical Cancer Hepatitis A Hepatitis B П Respiratory Problems Chemotherapy Cortisone Medication Hepatitis C Rheumatic Fever П Diabetes High Blood Pressure Rheumatism Are you allergic or have you reacted adversely to any of the following medications? YES NO YES NO YES NO Percodan Tetracycline Valium Aspirin П П Penicillin Darvon Latex Codeine Nitrous Oxide □ Local Anesthetic Erythromycin □ Sulfa Are you under a physician's care? What for? Have you ever taken any the following medications? YES NO YES NO Actonel Zometa What medications are you currently taking? Aredia П П Boniva П П Fosamax Herbal Family Physician Phone Number П Supplements Reclast Consent: The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Date

**Dentist Signature**