Central Virginia Dental Care, PLC DBA

ELIAS DENTAL

WELCOME TO OUR OFFICE. In order for us to render the proper dental treatment to you, please be kind enough to answer the following questions as accurately and completely as you can. Ask the receptionist for assistance if you are unsure of anything listed on the following pages. **THANK YOU!**

Patient Information:

Name_____ Age_____
Address_____
_____
Gender (M/F)_____ Marital Status_____
Height_____ Weight_____
Social Security #_____
Drivers License #_____

Date_____
Date of Birth_____
H: Phone_____
W: Phone_____
Other#_____
E-Mail_____
Referred By_____
_____

Spouse or Responsible Party Information

Name_____
Gender (M/F)_____ Marital Status_____ Birth Date_____ SS.#_____
Address:_____ Phone #'s H:_____
_____ W:_____

Employment Information

The following is for: [ ] the patient [ ] the person responsible for payment
Employer Name:_____
Address:_____

Insurance Information

Primary
Name of Insured:_____
Insured's Birth Date:_____ ID #_____ Group #_____
Insured's Address_____
Insured's Employer Name & Address_____
Patient's relationship to insured: [ ] Self [ ] Spouse [ ] Child [ ] Other
Insurance Plan Name & Address:_____
_____

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush & floss your teeth? _____
4. What texture brush do you use? __ Soft __ Medium __ Hard
5. Do you notice any odor on your floss?_____
6. Do you use breath fresheners (e.g. gum, strips, mints) to freshen your breath?_____
7. Do you practice regular tongue scraping?_____
8. Do you feel as if your breath could be fresher/cleaner after brushing & flossing?_____

DENTAL HISTORY	YES/NO
5. Do your gums bleed while brushing?	Y/ N
6. Do your gums bleed when flossing?	Y/ N
7. Do you feel pain on any of your teeth when brushing or flossing them?	Y/ N
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	Y/ N
9. Have you noticed any loosening of your teeth?	Y/ N
10 .Does food tend to become caught between your teeth?	Y/ N
11. Do you have any sores or lumps in or near your mouth?	Y/ N
12. Have you ever experienced any of the following problems in your jaw?	
a. Clicking?	Y/ N
b. Pain (joint, ear, side of face)?	Y/ N
c. Difficulty in opening or closing?	Y/ N
d. Difficulty in chewing?	Y/ N

	YES/NO
13. Have you had any head, neck, or jaw injuries?	Y/ N
14. Do you have frequent headaches?	Y/ N
15. Do you clench or grind your teeth while awake or asleep?	Y/ N
16. Do you bite your lips or cheeks frequently?	Y/ N
17. Have you ever had:	
a. Orthodontic treatment (braces)?	Y/ N
b. Oral surgery?	Y/ N
c. Gum treatment?	Y/ N
d. Your teeth ground or the bite adjusted?	Y/ N
e. Worn a bite plane or other appliance?	Y/ N
18 Are you satisfied with the appearance & color of your teeth? _____	Y/ N
19. Have you ever had an upsetting experience in the dental office_____	Y/N
20. Is there anything about having dental treatment that bothers you ?_____	

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

YES/NO	
1. Are you in good health?	Y/ N
2. Have there been any changes in your general health within the past year?	Y/ N
3. Date of your last physical exam?_____	
4. Physician's name_____	
Address _____	
Phone No._____	
5. Are you now under the care of a physician?	Y/ N
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain.	Y/ N
7. Are you taking any medicine(s) Including non-prescription medicine?	Y/ N
If yes, what medicine(s) are you taking?	
_____	

YES/NO	
8. Have you had any abnormal bleeding?	Y/ N
9. Do you bruise easily?	Y/ N
10. Have you ever required a blood transfusion?	Y/ N
11. Have you had a recent weight loss?	Y/ N
12. Do you smoke or use other tobacco	Y/ N
13. Do you have any chemical dependency's?	Y/N
14. Are you wearing contact lenses?	Y/ N
15. Do you have any disease, condition or problem not listed above that you think I should know about? _____	Y/ N

Women Only:

1. Are you pregnant or think you may be pregnant?	Y/ N
2. Are you nursing?	Y/ N
3. Are you taking birth control pills?	Y/ N

YES NO

Are you allergic to or have you had reactions to:

1. Local anesthetics like novocaine? Y/ N
2. Penicillin or other antibiotics? Y/ N
3. Sulfa drugs? Y/ N
4. Barbiturates, sedatives or sleeping pills? Y/ N
5. Aspirin? Y/ N
6. Iodine? Y/ N
7. Other? _____ Y/ N
8. Latex ? Y/N

Do you have or have you ever had the following:

1. Rheumatic heart disease or rheumatic fever? Y/ N
2. Scarlet fever? Y/ N
3. Heart defect or heart murmur? Y/ N
4. Heart trouble, heart attack, or angina? Y/ N
   a. Do you have pain in your chest upon exertion? Y/ N
   b. Are you ever short of breath after mild exercise? Y/ N
   c. Do your ankles swell? Y/ N
   d. Do you get short of breath when you lie down? Y/ N
   e. Do you require extra pillows when you sleep? Y/ N
5. Pacemaker. ? Y/ N
6. Heart surgery. ? Y/ N
7. High blood pressure. Y/ N
8. Low blood pressure? Y/ N
9. Hepatitis, jaundice or liver disease? Y/ N
10. Stroke? Y/ N
11. Sinus trouble? Y/ N
12. Lung or breathing problems? Y/ N
13. Asthma or hay fever? Y/ N
14. Hives or skin rash? Y/ N
15. Fainting spells or seizures? Y/ N
16. Diabetes? Y/ N
17. AIDS or HIV infection? Y/ N
18. Thyroid problems? Y/ N
19. Allergies? Y/ N
20. Arthritis or rheumatism? Y/ N
21. Joint replacement or implant? Y/ N
22. Stomach ulcer? Y/ N
23. Kidney trouble? Y/ N
24. Tuberculosis? Y/ N
25. Persistent cough? Y/ N
26. Cough that produces blood? Y/ N
27. Cancer? Y/ N
28. Sexually transmitted disease? Y/ N
29. Epilepsy? Y/ N
30. Anemia? Y/ N
31. Leukemia? Y/ N
32. Glaucoma? Y/ N

The above information is accurate & complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

I hereby authorize Central Virginia Dental Care, PLC DBA Elias Dental to release the information requested to the insurance company named herein. I hereby assign payment directly to the above-named dentist of benefits otherwise payable to me. I understand that regardless of insurance coverage, I am financially responsible for all charges incurred. I agree in the event my account must be submitted to an attorney or other agency for collection, I am responsible for all attorney's fees, collection fees, court costs and interest.

PLEASE BE ADVISED THERE WILL BE A $35 CHARGE FOR ANY APPOINTMENT CACELLED WITH LESS THAN 2 BUSINESS DAYS NOTICE.

Signature_____ **Date** _____