City Place Dental

8780 Georgia Avenue, Silver Spring, MD 20910 Phone: (301) 585-1515

Please complete **Dental History** information on reverse side

PATIENT INFORMATION

PATIENT'S NAME (Last, First, M.I.):

BIRTHDATE: | AGE: | SOCIAL SECURITY NO.:

EMAIL AND CELL PHONE:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

REASON FOR THIS VISIT:

PHYSICIAN NAME: | PHONE NO.:

PHYSICIAN ADDRESS:

IN CASE OF EMERGENCY NOTIFY: | RELATIONSHIP:

RESPONSIBLE PARTY INFORMATION

NAME (Last, First, M.I.): | MARITAL STATUS:

ADDRESS (Street, City, State, Zip):

HOW LONG AT THIS ADDRESS? | SPCIAL SECURITY NO.:

HOME PHONE: | WORK PHONE:

BIRTHDATE: | DRIVER'S LICENSE NO.:

RELATION TO PATIENT: | OCCUPATION:

EMPLOYER: | NO. YEARS EMPLOYED:

MEDICAL HISTORY Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible health care to you (or your child), it is necessary to have the following information. Have you (the patient) ever had or do you now have the following, if yes, please indicate "yes" and circle or write in illness or condition.

	YES	NO		YES	NO
Asthma, hay fever, sinusitis, or other allergies	☐	☐	Communicable disease: tuberculosis, herpes or venereal	☐	☐
Allergy to penicillin, aspirin, local or general anesthetic, or other drugs or materials such as latex (in gloves); Specify:	☐	☐	Acquired Immune Deficiency Syndrome (AIDS)/A.R.C./HIV positive	☐	☐
Blood pressure or heart problems	☐	☐	Do any wounds heal slowly or present complications?	☐	☐
Rheumatic fever or heart murmur or mitral valve prolapse	☐	☐	Are you presently taking any medicine? Specify:	☐	☐
Pacemaker or open-heart surgery or heart valve replacement	☐	☐	Are you presently under the care of a physician?	☐	☐
Diabetes, liver, kidney, thyroid, or lung problems	☐	☐	When was your last physical exam?	☐	☐
Ulcer or stomach problems	☐	☐	Have you ever been hospitalized? Date: Reason:	☐	☐
Hepatitis or jaundice	☐	☐	Have you had any x-ray treatments or chemotherapy?	☐	☐
Epilepsy or nervous disorders	☐	☐	Any other illness?	☐	☐
Bleeding or clotting disorders	☐	☐	Are you presently on a diet?	☐	☐
Arthritis or hip replacement surgery or prosthetic joint replacement	☐	☐	Are you taking birth control pills?	☐	☐
			Are you pregnant	☐	☐

Patient/Guardian Signature **Date** | **Doctor's Signature** **Date**

CERTIFICATION OF PAYMENT

I accept responsibility for paying all balances due at the time of service. In the event the account becomes delinquent, I accept responsibility for paying interest and collection fees arising as a result of my failure or delinquency in settling this debt, as well as all legal fees incurred pursuant to obtaining payment.

Patient/Guardian Signature **Date** | **Doctor's Signature** **Date**

City Place Dental

8780 Georgia Avenue, Silver Spring, MD 20910 Phone: (301) 585-1515

Please complete **Medical History** information on reverse side

PATIENT INFORMATION

INSURED'S NAME (Last, First, M.I.):

INSURED'S ADDRESS:

INSURED'S PHONE NO.: | INSURED'S SOCIAL SECURITY NO.:

INSURANCE COMPANY NAME:

INSURANCE COMPANY ADDRESS:

INSURED'S EMPLOYER

INSURED'S MEMBER ID NO.: | GROUP NO.: | LOCAL NO.

WHAT IS YOUR CHIEF DENTAL COMPLAINT?

DATE OF LAST DENTAL EXAM: | DATE OF LAST FULL MOUTH X-RAY: | WHERE TAKEN:

	YES	NO
Have you had trouble from previous dental care?	☐	☐
Do you have pain in your jaw or near your ears?	☐	☐
Do you have any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
Have you experienced any growths or sore spots in or around your mouth?	☐	☐
Does any part of your mouth hurt when clenched?	☐	☐
Have you ever had Novocaine or other local anesthetic?	☐	☐
Have you ever had Nitrous Oxide (laughing gas)?	☐	☐
Have you ever had general anesthesia?	☐	☐
Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthesia?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had prolonged bleeding following extractions in the past?	☐	☐
Do your gums bleed?	☐	☐
Do you have a bad taste in your mouth or mouth odor?	☐	☐
Have you ever had instructions on the care of your gums?	☐	☐
Do you chew on only one side of your mouth? If so, why?	☐	☐
Do you habitually clench or grind your teeth during the night or day?	☐	☐
Is any part of your mouth sensitive to pressures or irritants (hot, cold, or sweets?	☐	☐
Is there any other problem not covered above that you would like to discuss?	☐	☐

Certification of Understanding: I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff. Responsible for any errors or omissions that I may have made in the completion of this form.

PATIENT/GUARDIAN SIGNATURE | **DATE**

GENERAL CONSENT: I hereby authorize the staff of City Place Dental to employ such treatments and technical procedures as may be deemed necessary or advisable in the course of my dental treatment. I understand that this authorization will cove all aspects of routine dental care, including administration of X-rays, photographic records, local anesthetics, sedative drugs, and treatments including preventive and restorative dentistry (cleaning and scaling of teeth, fillings, root canal treatments, orthodontic care, and the fitting of dentures, crowns, and bridges), and minor surgical procedures (extractions and gum surgery). I understand that this authorization shall remain in full effect for the present visit, as well as for subsequent visits during the course of treatment. All of my questions have been answered.

PATIENT/GUARDIAN SIGNATURE | **DATE**

WITNESS: | **DATE**