CHAVIS DENTAL

General & Cosmetic Dentistry
Your Best Smile

CONFIDENTIAL PATIENT RECORD

NEW PATIENT INFO

1145 19th St NW, Washington, DC 20036
Phone: (202) 833-3377

Chart No.__________
Office Use Only

Patient Name: ____ Date: ____________
Last First Mid. Initial Preferred

Gender: M / F ______ Domestic Partner ______Married ______Single ______Divorced ______Other ____________

Social Sec #: ______________________ Date of Birth: (MM/DD/YYYY) ______________

Home Tel: ______________ Work Tel: ______________ Ext #________Cell: ______________

e-Mail Address: ______________________ Street Address: ______________________

City: ______________________ State: ____________Zip Code: ______________

Preferred method of communication: Text______________ Cell______________ Email______________

Health Information

Date of Last Dental Visit: (MM/DD/YYYY)____________ Last X-Rays: ______________Reason for this visit: ______________

Former Dentist: ______________ Address: ______________________

How often do you floss? ______________ How often do you brush? ______________

Have you had any of the following conditions? Please check those that may apply:

- ☐ AIDS
- ☐ Allergies ______________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer ______________
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries ______________
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due Date: ______________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Drug/Medicine Allergies
- ☐ Codeine
- ☐ Penicillin
- ☐ Other: ______________
- ☐ Other Medical Conditions: ______________

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: ______________________

Are you currently taking any medications? ☐ Yes ☐ No ______________

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: ______________________

Have you ever had any serious illness, operations, or blood tranfusions? ☐ Yes ☐ No

Name of Physician: ______________________ Tel: ______________

Do you have any health problems (no matter how trivial) that need further clarification? ☐ Yes ☐ No
If yes, please explain: ______________________

Please check if you have had or do currently have problems with any of the following conditions:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Grinding Teeth
- ☐ Periodontal Treatment
- ☐ Sensitivity to Sweets
- ☐ Sensitivity to Hot or Cold
- ☐ Sensitivity when Biting
- ☐ Clicking or Popping Jaw
- ☐ Loose Teeth or Broken Fillings
- ☐ Sores or Growths in Mouth
- ☐ Food Collection between Teeth
- ☐ Frequent Headaches
- ☐ Discolored Teeth
- ☐ Recession of Gum Tissues
- ☐ Please indicate any condition that you may be experiencing, not described above: ______________________

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Work ☐ Internet ☐ Other ______

Name of person or office referring you to our practice: ______

Spouse or Responsible Party Information

The following is for: ☐Patient's Spouse ☐ Person Responsible for Payment

Name: ______ Date: ______

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Sec #: ______ Date of Birth: (MM/DD/YYYY) ______

Telephone: Home: ______ Work: ______ Ext. ______ Cell: ______

e-Mail Address: ______ Street Address: ______

______

City: ______ State: ______ Zip Code: ______

Employment Information

The following is for: ☐Patient's Spouse ☐ Person Responsible for Payment

Employer Name: ______ Occupation: ______

e-Mail Address: ______ Street Address: ______

______ Telephone: ______

City: ______ State: ______ Zip Code: ______

Primary Insurance Information

Name of Insured: ______ (Last, First, Mid. Initial) Is insured a patient? ☐ Yes ☐ No

Insured's Date of Birth: (MM/DD/YYYY) ______ ID # ______ Group # ______

Insured's Address: ______

City: ______ State: ______ Zip Code: ______

Insured's Employer Name: ______ Address: ______

City: ______ State: ______ Zip Code: ______

Patient's relationship to insured: ☐Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address: ______

City: ______ State: ______ Zip Code: ______

Telephone: ______

Secondary Insurance Information (If applicable)

Name of Insured: ______ Is insured a patient? ☐ Yes ☐ No

Insured's Date of Birth: (MM/DD/YYYY) ______ ID # ______ Group # ______

Insured's Address: ______

City: ______ State: ______ Zip Code: ______

Insured's Employer Name: ______ Address: ______

City: ______ State: ______ Zip Code: ______

Patient's relationship to insured: ☐Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address: ______

City: ______ State: ______ Zip Code: ______

Telephone: ______

Consent for Service

As a condition of your treatment by this office, financial arrangements must be made in advance. I authorize my insurance company to pay Chavis Dental all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I also authorize Chavis Dental to release all information necessary to secure payment of benefits. To the best of my knowledge all information provided is true and correct. If I ever have any change in health, I will inform the doctor at the next appointment without fail. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to my dental care. I have read the above conditions of treatment and agree to their content.

______ Date: ______ Relationship to Patient: ______

(Signature of patient, parent or guardian) © Chavis Dental. All rights Reserved.