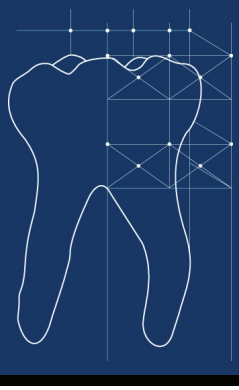

CONFIDENTIAL PATIENT RECORD

New Patient info

CHAVIS DENTAL

1145 19th Street NW • Washington, DC 20036 • Tel: 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: _____

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 - friend ❒ Another patient - relative

❒ Dental Office ❒ Yellow Pages ❒ Newspaper ❒ School ❒ 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: _____ Is insured a patient? ❒ Yes ❒ No

Last First Mid. Initial

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 this form. I have read the above conditions of treatment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

(Signature of patient, parent or guardian)