ADVANCE DENTAL CARE CENTER
General & Cosmetic Dentistry

2111 JEFFERSON DAVIS HIGHWAY • #1 SOUTH CRYSTAL PLAZA • ARLINGTON • VIRGINIA 22202 • TEL:(703)415-0505 • FAX: (703)415-7596

PATIENT INFORMATION

ALL INFORMATION ON THIS FORM MUST BE COMPLETED

NAME: _____(_____)
FIRST MIDDLE INTIAL LAST (PREFERRED)

ADDRESS: _____
NUMBER AND STREET NAME APT. NO.

_____
CITY STATE ZIP CODE

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____-_____-_____

PHONE: Home: _____ E-MAIL: _____

Work: _____ GENDER: ☐ MALE ☐ FEMALE

Mobile:_____ ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ MINOR ☐ PARTNERED

Employer Name: _____ Occupation:_____

EMERGENCY CONTACT**:** _____
NAME PHONE RELATIONSHIP

INSURANCE INFORMATION

Are you the Subscriber/Main Card holder? : Y / N

If not, Subscribers full name: _____ DOB:_____Relationship to patient:_____

PRIMARY DENTAL / MEDICAL CARRIER

INSURANCE NAME: _____ INSURANCE PHONE NUMBER:_____

ID #:_____GROUP#:_____EMPLOYER NAME:_____

SECONDARY DENTAL CARRIER

INSURANCE NAME: _____ INSURANCE PHONE NUMBER:_____

ID #:_____GROUP#:_____EMPLOYER NAME:_____

INSURANCE AUTHORIZATION

I hereby authorize release of information necessary to process my dental benefit claims and for payment otherwise payable to me to be made directly to Advance Dental Care Center. I understand that I am responsible for my portion of the approved fee as determined by my plan, and that payment is due at the time services are rendered.

PAYMENT: A service charge of 1.5% per month on the unpaid balance will be charged on accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Any overdue invoices will void the Guarantee. Client agrees to pay reasonable attorney fees and collection costs if it takes legal action to collect any unpaid balance. Payment should be made to Advance Dental Care Center.

By signing this Agreement, the undersigned agrees to all terms and conditions set forth herein. No other agreement, written or oral, exists between the parties.

_____ _____
Name Date

WHO CAN WE THANK FOR REFERRING YOU? _____

REASON FOR TODAY'S VISIT? _____

Name_____ **Date of last visit**_____

PLEASE PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE OR EVER HAD ANY OF THE FOLLOWING:

AIDS/HIV	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Scarlett Fever	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Bleeding abnormally,	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tumor or growth	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

**Do you require antibiotic pre-medication prior to any dental treatment? ☐ Yes ☐ No

**Have you had any recent surgeries we should know about? Please include dates: _____

_____

Women:

Taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due Date: _____ Are you nursing? ☐ Yes ☐ No

PLEASE PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Bad Breath	☐ Yes	☐ No	Foreign Object	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Grinding teeth	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Gums swollen or tender	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Chew on one side of the mouth	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No	Sores or growths	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No			
Dry mouth	☐ Yes	☐ No	Mouth Pain, brushing	☐ Yes	☐ No	How often do you floss?_____		
Fingernail biting	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No			
Food collection between the teeth	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No	How often do you brush?_____		

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

Pharmacy Name:_____

Phone (_____)_____

ALLERGIES

☐ **NONE**

☐ Local Anesthetic

☐ Penicillin

☐ Amoxicillin

☐ Latex

☐ Iodine

☐ Aspirin

☐ Codeine

☐ Barbiturates (sleeping pills)

☐ Other_____