Westwood Park Dental - John R. Guirguis, DMD

10936 Patriot Highway (Suite 4737) - Fredericksburg, VA 22408 - (540) 371-0920

PATIENT INFORMATION Today's Date _____

Name _____ ( ) Married ( ) Single ( ) Minor / ( ) Male ( ) Female

SS# _____ Driver License # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Do you prefer to receive calls at: ( ) Home ( ) Cell ( ) Work ( ) No Preference

Email Address _____

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City_____ State _____ Zip _____

Spouse or Parent's Name _____ Phone (_____)_____

Person to contact in case of emergency _____Phone (_____)_____

Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY

Person Responsible for account ( ) Self ( ) Spouse ( ) Father ( ) Mother ( ) Guardian

Name of person responsible for account _____ Phone (_____)_____

INSURANCE INFORMATION

Insurance Company: _____ Identification #:_____

Name of policy holder: _____ Relationship to patient: _____

Birthdate _____ SS# _____ Phone (_____)_____

Name of Employer _____ Address _____

Signature of Patient, Parent or Guardian: _____ Date: _____

Westwood Park DENTAL

PATIENT MEDICAL HISTORY

Patient's Name: _____ Birthdate: _____

CHECK ONE	YES	NO
1. Are you under medical treatment now?	( )	( )
2. Have you ever been hospitalized for any surgical operation or serious illness?	( )	( )
3. Are you taking any medication(s), including non-prescription medicine?	( )	( )
4. Do you use tobacco?	( )	( )
5. Do you drink alcohol?	( )	( )
6. Are you wearing contact lenses?	( )	( )
7. Are you or have you ever taken Fosamax, Actonel, Boniva, Reclast or any other Bisphosphonates (for Osteoporosis)?	( )	( )
8. Have you ever taken Fen-Phen or Redux?	( )	( )
9. Are you allergic to PENICILLIN or any other antibiotics?	( )	( )
10. Are you allergic to LOCAL ANESTHETICS (e.g. Novocaine)?	( )	( )
11. Does your medical doctor recommend prophylactic antibiotics before any dental procedures?	( )	( )
12. Women only: Are you currently pregnant or think you may be pregnant?	( )	( )
13. Women only: Are you currently nursing?	( )	( )

If yes, please describe:

If yes, please describe:

If yes, please list:

If yes, please list:

14. Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure	( )	( )	Heart Disease	( )	( )	Chest Pain	( )	( )
Low Blood Pressure	( )	( )	Heart Murmur	( )	( )	Stroke	( )	( )
Heart Valve Replacement	( )	( )	Heart Attack	( )	( )	Psychiatric Care	( )	( )
AIDS or HIV Infection	( )	( )	Cardiac Pacemaker	( )	( )	Cancer	( )	( )
Joint Replacement or Implant	( )	( )	Respiratory Problems	( )	( )	Anemia	( )	( )
Stomach Troubles / Ulcers	( )	( )	Hay Fever / Allergies	( )	( )	Angina	( )	( )
Fainting / Seizures	( )	( )	Hepatitis / Jaundice	( )	( )	Glaucoma	( )	( )
Epilepsy / Convulsions	( )	( )	Tuberculosis	( )	( )	Asthma	( )	( )
Radiation Therapy	( )	( )	Easily Winded	( )	( )	Emphysema	( )	( )
Rheumatic Fever	( )	( )	Swollen Ankles	( )	( )	Arthritis	( )	( )
Liver Disease	( )	( )	Kidney Disease	( )	( )	Leukemia	( )	( )
Thyroid Problem	( )	( )	Diabetes	( )	( )	Osteoporosis	( )	( )

PATIENT DENTAL HISTORY

Date of Last Dental Exam: _____

	YES	NO
1. Do your gums bleed while brushing and flossing?	( )	( )
2. Are your teeth sensitive to hot /cold liquids/foods?	( )	( )
3. Are your teeth sensitive to sweet/sour liquids/foods?	( )	( )
4. Do you feel pain to any of your teeth?	( )	( )
5. Do you have any sores or lumps in or near you mouth?	( )	( )
6. Have you had any head, neck or jaw injuries?	( )	( )
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	( )	( )
b) Pain (joint, ear, side of face)?	( )	( )
c) Difficulty in opening or closing?	( )	( )
d) Difficulty in chewing?	( )	( )
8. Do you have frequent headaches?	( )	( )
9. Do you clench or grind your teeth?	( )	( )
10. Do you bite your lips/cheeks frequently?	( )	( )
11. Have you ever had any difficult extractions in the past?	( )	( )
12. Have you had any orthodontic work?	( )	( )
13. Have you ever had any prolonged bleeding following extractions?	( )	( )
14. Have you ever had instruction on the correct method of brushing your teeth?	( )	( )
15. Have you had instructions on the care of your gums?	( )	( )

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing inaccurate information can be dangerous to my health.

Signature of Patient, Parent or Guardian: _____ Date: _____