Westwood Park Dental - John R. Guirguis, DMD

3DWULRWH[JKZDKXWH - Fredericksburg, VA 2240 - (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: _____**