Burke Family and Cosmetic Dentistry
6116 Rolling Road, Suite 108
Springfield, VA 22152
Tel: (703) 764-1112
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Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential) Patient Number____________________________

Name____Date _____________________________________

Gender__________ Male / Female (Please Circle) Email Address ______________________________

Soc. Sec. #____ Birth date________________ Home Phone ______________________________

Address____ City______________________ State_________________ Zip___________

Check Appropriate Box ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

If Student, Name of School/College_______________________ City_______________________ State _____ ☐Full Time ☐Part Time

Patient's or Parent's Employeer____Work Phone_______________________________

Business Address_______________________________________ City______________________ State_________________ Zip___________

Spouse or Parent's Name_________________________________ Employer___________________Work Phone____________________________

Business Address_______________________________________ City______________________ State_________________ Zip___________

Whom May We Thank for Referring You?
____

Person to Contact in Case of
Emergency____

Responsible Party

Name of Person Responsible for this Account____Relationship to Patient_______________________

Addresss____Home Phone ______________________________

Employer____Work Phone_____________________SS#______________________________________

Is this Person Currently a Patient in our Office? ☐Yes ☐No

Insurance Information

Name of Insured____ Relationship to Patient______________________

Birth date______________________________________ Social Security #_____________________ Date Employed____________________________

Employer Address_______________________________________City_______________________________ State_______________ Zip___________

Insurance Company_____________________________________ Group #____________________________ Policy/ID#________________________________

Ins. Co. Address____ City_______________________________ State_______________ Zip___________

How Much is Your Deductible?___________________________ How Much Have You Used?____________ Max. Annual Benefit________________________

Do You Have Any Additional Insurance? ☐Yes ☐No If Yes, Complete the Following

Name of Insured____ Relationship to Patient______________________

Birth date______________________________________ Social Security #_____________________ Date Employed____________________________

Employer Address_______________________________________City________________________________ State________________ Zip___________

Insurance Company______________________________________ Group #____________________________ Policy/ID#______________________________

Ins. Co. Address____ City________________________________ State________________ Zip___________

How Much is Your Deductible?___________________________ How Much Have You Used?____________ Max. Annual Benefit_____________________

Patient Medical History

Physician____ Office Phone________________________ Date of Last Exam________________________

1. Are you under medical treatment now? ☐Yes ☐No

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐Yes ☐No
If yes please
explain.____

3. Are you taking any medications including non-prescription medicine? ☐Yes ☐No
If yes, what medication(s) are you taking?
____

4. Have you ever taken Phen/Fen/Redux? ☐Yes ☐No 5. Do you use tobacco? ☐Yes ☐No

6. Do you use controlled substances? ☐Yes ☐No 7. Do you have or have you had any of the following?

High Blood Pressure	☐Yes	☐No	Heart Disease	☐Yes	☐No	Chest Pains	☐Yes	☐No
Heart Attack	☐Yes	☐No	Cardiac Pacemaker	☐Yes	☐No	Easily Winded	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Stroke	☐Yes	☐No
Swollen Ankles	☐Yes	☐No	Angina	☐Yes	☐No	Hay Fever/Allergies	☐Yes	☐No
Fainting/Seizures	☐Yes	☐No	Frequently Tired	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Asthma	☐Yes	☐No	Anemia	☐Yes	☐No	Radiation Therapy	☐Yes	☐No
Low Blood Pressure	☐Yes	☐No	Emphysema	☐Yes	☐No	Glaucoma	☐Yes	☐No
Epilepsy/Convulsions	☐Yes	☐No	Cancer	☐Yes	☐No	Recent Weight Loss	☐Yes	☐No
Leukemia	☐Yes	☐No	Arthritis	☐Yes	☐No	Liver Disease	☐Yes	☐No
Diabetes	☐Yes	☐No	Joint Replacement or Implant	☐Yes	☐No	Heart Trouble	☐Yes	☐No
Kidney Diseases	☐Yes	☐No	Hepatitis/Jaundice	☐Yes	☐No	Respiratory Problems	☐Yes	☐No
AIDS or HIV Infection	☐Yes	☐No	Sexually Transmitted Disease	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No
Thyroid Problem	☐Yes	☐No	Stomach Troubles/Ulcers	☐Yes	☐No	Other_____________	☐Yes	☐No

9. Are you allergic to or have you had reactions to the following?

Local Anesthetics (e.g. Novocain) ☐Yes ☐No Penicillin or other Antibiotics ☐Yes ☐No

Sulfa Drugs	☐Yes	☐No	Barbiturates	☐Yes	☐No
Sedatives	☐Yes	☐No	Iodine	☐Yes	☐No
Aspirin	☐Yes	☐No	Any metals (e.g. nickel, mercury, etc.)	☐Yes	☐No
Latex Rubber	☐Yes	☐No	Other____________________________	☐Yes	☐No

10. Women Only:

a. Are you pregnant or think you may be pregnant? ☐Yes ☐No

b. Are you nursing? ☐Yes ☐No

c. Are you taking oral contraceptives? ☐Yes ☐No

Patient Dental History

Name of Previous Dentist ____ Date of Last Exam_________________________

Previous Dentist's Location ____ Date of Last Cleaning______________________

1. Do your gums bleed while brushing or flossing? ☐Yes ☐No
2. Are your teeth sensitive to hot or cold liquids/foods? ☐Yes ☐No
3. Are your teeth sensitive to sweet or sour liquids/foods? ☐Yes ☐No
4. Do you feel pain to any of your teeth? ☐Yes ☐No
5. Do you have any sores or lumps in or near your mouth? ☐Yes ☐No
6. Have you had any head, neck or jaw injuries? ☐Yes ☐No
7. Have you ever experienced any of the following problems in your jaw?
   - Clicking ☐Yes ☐No
   - Pain (joint, ear, side of face) ☐Yes ☐No
   - Difficulty in opening or closing ☐Yes ☐No
   - Difficulty in chewing ☐Yes ☐No
8. Do you clench or grind your teeth? ☐Yes ☐No
9. Have you ever had any difficulty extractions in the past? ☐Yes ☐No
10. Have you ever had any prolonged bleeding following extractions?☐Yes ☐No
11. Have you had any orthodontic treatment? ☐Yes ☐No

Authorization and Release

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 incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me and/or my child during the period of such Dental care to third party and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____Signature of patient (or parent if minor)

Doctor's Comment____

Signature ______________________________ Date ____________________________________