Bethesda Chevy Chase Smiles

New Patient Information Form

(Please print all information clearly)

Full Name (First M.I Last) _____ SSN _____ Date of Birth _____ Today's Date _____

Address _____ City _____ State _____ Zip Code _____

Best Phone Number _____ Email Address _____ Marital Status _____

Please indicate your preferred method of contact: ☐ Text ☐ Email ☐ Phone

Patient or Parent's Employer _____ Work Phone Number _____

Business Address _____ City _____ State _____ Zip Code _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Emergency Contact _____ Phone Number _____

If referred to BCC Smiles, please provide the name of the person who referred you. _____

RESPONSIBLE PARTY - If Under 18

Name of Person Responsible for This Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Date of Birth _____ Driver's License Number _____

Employer _____ Work Phone Number _____

Is this person currently a patient at BCC Smiles : ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured | SSN | Date of Birth | Relationship to Patient

Employer | Work Phone Number

Insurance Company | ID Number

Insurance Company Address | City | State | Zip Code

Do you have any additional Dental Insurance? ☐ **Yes** ☐ **No** **If YES, complete the following section otherwise please leave it blank**

Name of Insured | SSN | Date of Birth | Relationship to Patient

Employer | Work Phone Number

Insurance Company | ID Number

Insurance Company Address | City | State | Zip Code

Signature of Patient or Parent

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of last visit _____

	YES	NO
1. Are you under medical treatment currently?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you currently taking any medication(s) including "over the counter" non-prescription medication?	☐	☐

If "YES" please list here _____

4.Do you or have you ever used tobacco products?	☐	☐
5. Do you have/had any history of substance abuse?	☐	☐
6. Do you or are you wearing contact lenses ?	☐	☐

7. Are you allergic to or ever had an allergic reaction to any of the following?

	YES	NO		YES	NO
Aspirin	☐	☐	Sedatives	☐	☐
Barbiturates	☐	☐	Sulfa Drugs	☐	☐
Local Anesthetics (i.e. Novocain)	☐	☐	Iodine	☐	☐
Penicillin or other antibiotics	☐	☐			

Others _____

8. Women only:

	YES	NO
a) Are you pregnant or think you may be pregnant ?	☐	☐
b) Are you nursing ?	☐	☐
c) Are you taking birth control drugs ?	☐	☐

9. Do you have or ever had any of the following:

	YES	NO		YES	NO		YES	NO
AIDS / HIV Infection	☐	☐	Fainting / Seizures	☐	☐	Leukemia	☐	☐
Anemia	☐	☐	Frequently Tired	☐	☐	Liver Disease	☐	☐
Angina	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐
Arthritis	☐	☐	Hay Fever / Allergies	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Heart Attack	☐	☐	Recent Weight Loss	☐	☐
Cancer	☐	☐	Heart Disease	☐	☐	Respiratory Problems	☐	☐
Cardiac Pacemaker	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever	☐	☐
Chest Pains	☐	☐	Heart Trouble	☐	☐	Sexually Transmitted Disease	☐	☐
Diabetes	☐	☐	Hepatitis / Jaundice	☐	☐	Stroke	☐	☐
Easily Winded	☐	☐	High Blood Pressure	☐	☐	Swollen Ankles	☐	☐
Emphysema	☐	☐	Joint Replacement	☐	☐	Tuberculosis	☐	☐
Epilepsy / Convulsions	☐	☐	Kidney Disease	☐	☐		☐	☐

Other _____

Date of last dental visit: _____

Were x-rays taken at this time: Yes ☐ No ☐

Name of Previous Dentist/Practice: _____

Patient Dental History

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

Signature and Consent

I certify that I have read and understand the information above to the best of my knowledge. The questions above have been accurately answered and I understand that providing incorrect information could be dangerous to my health.

Signature Field

Today's Date

The Following Section is for Doctors Use Only

Dentist's Comments

Dentist Signature **Date**

Date	Medical History Updates