Mona Bhaskar, DDS 9844-A Main Street Fairfax, VA 22031
PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Today's Date: _______________________

PATIENT INFORMATION

Patient's Name: ____ Sex: M/F Date Of Birth:_______________
Social Security #: ________________If Patient is a Minor, Parents/Guardian Name: ______________________________
Who may we thank for referring you to our office: ____

RESPONSIBLE PARTY INFORMATION

Name: ____Marital Status: __________________________
Mailing Address: ____________________________ City: ________________ State _______ Zip Code: ________
Home Phone: ______________________Cell Phone: _____________________Work Phone: ___________________
E-Mail :____________________________
Social Security #: _________________________ Date Of Birth: ___________
Driver's License #: _________________________ State License Issued: __________ Expires: ________________
Employer: ____________________________ Occupation: _______________ No. of yrs employed: _____________

Who do we contact in case of emergency? _____________________________________Phone#:________________

DENTAL INSURANCE INFORMATION

Primary Carrier

Policy Holder's Name: ________________________________Policy Holder's Social Security Number: ______________
Insurance Company: _____________________________ Insurance Company Telephone: ________________
Insured's Employer: ____ Group Number:________________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:__________ ________________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:____________________________________
____

Women:

- ❑ May be pregnant
  Expected delivery date: ____________
- ❑ Taking hormones or contraceptives

Please list any medications and supplements you are currently taking

____

____

Name and number of your physician ____

____

DENTAL HEALTH

Yes	No	
☐	☐	Do you brush your teeth twice daily? If not, how often____________________
☐	☐	Do you floss? How often? ____________________
☐	☐	Are you having any pain or discomfort at this time?
☐	☐	Do your gums bleed while brushing and flossing?
☐	☐	Are your teeth sensitive to hot or cold liquids/foods?
☐	☐	Have you ever experienced any of the following problems with your jaw? (Circle all that apply): clicking pain difficulty in opening and closing difficulty in chewing
☐	☐	Do you have frequent headaches?
☐	☐	Do you clench or grind your teeth? If yes, when? ____________________
☐	☐	Have you ever had any orthodontic treatment? If so, do you wear a retainer? ____________________
☐	☐	Have you ever had facial surgery? If so, when and what area of your face? ____________________
☐	☐	Have you ever had any type of trauma to your mouth, jaw or face? If yes, describe: ____________________
☐	☐	Do you wear dentures or partials? If so, date of placement: ____________________
☐	☐	Do you have any concerns about bad breath odor?
☐	☐	Are you pleased with the appearance of your teeth when you smile?
☐	☐	Are you pleased with the color of your teeth?
☐	☐	Are you nervous about dental treatment

AUTHORIZATION

I authorize and give informed consent to Dr Bhaskar to perform agreed upon procedures that may be necessary for proper dental care. These may include but are not limited to, diagnostic (radiographs and oral exams), therapeutic procedures, local anesthesia and the use of other medications as indicated. I confirm that the information on this page and the medical history are correct to the best of my knowledge. I hereby authorize insurance payments to go directly to the dental office. I understand that I am responsible for the cost of the treatment and services rendered regardless of my insurance benefits.
I also authorize Mona Bhaskar, DDS to discuss my protected health information with the persons listed below:

Name and Relationship: ____

I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Bhaskar to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform her.

Signed:____Date:____________________