AA - Fort Eustis VA
Bldg 1527 Washington Blvd
Fort Eustis, VA 23604
Ph # : 757-297-0148

Patient Personal Information

Title ______ Nickname ______

Last, First ______ ______ ______

Address ______

______

City, State, Zip ______

Email ______

Health Care Guardian Name ______

Health Care Guardian Phone # ______

Birth Date ______ Age ______

Marital Status ______ Sex ______

Home # ______ Work # ______

Cell # ______ Drive Lic ______

Emergency Contact ______ Emergency Phone # ______

Student ______ SSN ______

School Name ______

Referral Type ______

Person responsible/guarantor for paying bills

Title ______ Nickname ______

Last, First ______

Address ______

______

City, State, Zip ______

Email

Birth Date ______ Age ______

Marital Status ______ Sex ______

Home # ______ Work # ______

Cell # ______ Drive Lic ______

SSN ______

Do you have Primary Dental Insurance? **No**

__ Yes __ No

Group No/Name

Insurance Name

Phone #

Employer Name

Subscriber Last, First

Subscriber Address

City, State, Zip

Relationship to Patient

Birth Date

Subscriber ID

Do you have Secondary Dental Insurance? **N**

__ Yes __ No

Group No/Name

Insurance Name

Phone #

Employer Name

Subscriber Last, First

Subscriber Address

City, State, Zip

Relationship to Patient

Birth Date

Subscriber ID

Patient Medical Information

Allergic To

Y N Aspirin
Y N Amoxicillin
Y N Barbiturates/Sleeping Pills
Y N Codeine/Other narcotics
Y N Erythromycin
Y N Iodine
Y N Latex Rubber
Y N Local Anesthetics

Y N Allergies - food, drugs, insec
Y N Alcohol/Drug Abuse
Y N Anemia/Leukemia
Y N Ankles Swell
Y N Anorexia/Bulimia
Y N Arthritis
Y N Asthma/Hay Fever
Y N Blood clotting problems
Y N Blood Transfusion

Y N Autism
Y N Epilepsy
Y N Fainting Spells/Seizures
Y N Frequent Headaches
Y N Frequently dry mouth
Y N Gall Bladder Trouble
Y N Heart Attack/Stroke
Y N Heart disease/Angina
Y N Heart murmur

Y N Mitral Valve Prolapse
Y N Nervous Disorders
Y N Persistent Diarrhea
Y N Premedicate
Y N Rheumatic Fever
Y N Rheumatic Heart disease
Y N Sexually transmitted disease
Y N Shortness of Breath
Y N Sinus trouble

Y	N		Y	N		Y	N		Y	N	
☐	☐	Metals	☐	☐	Bronchitis	☐	☐	Hepatitis/Jaundice	☐	☐	Stomach Ulcers
☐	☐	Penicillin	☐	☐	Cancer/ tumor or Growth	☐	☐	High Blood Pressure	☐	☐	Thyroid Problems
☐	☐	No Epinephrine	☐	☐	Cardiac Pacemaker	☐	☐	Hives/Skin Rash	☐	☐	Tuberculosis
☐	☐	Prior Hepatitis	☐	☐	Chest Pain upon Exertion	☐	☐	hospitalized other than birth	☐	☐	Unusual Weight Loss
☐	☐	Sulfa Drugs	☐	☐	Color Blindness	☐	☐	Joint Replacement	☐	☐	ulcer
☐	☐	AIDS/HIV infection	☐	☐	Contact Lenses	☐	☐	Kidney/Bladder trouble	☐	☐	Urinate Frequently
		Check, if applicable	☐	☐	Damaged Heart Valve	☐	☐	Liver Disease	☐	☐	see patient note
☐	☐	ADHD	☐	☐	Diabetes	☐	☐	Low Blood Pressure	☐	☐	Sickel Cell
☐	☐	Allergies - Environmental	☐	☐	Emphysema	☐	☐	Mental health problems	☐	☐	Sinus

Dental Questionnaire

Dental Questionnaire

Name of Dentist ____________________

Phone ____________________

Date of your Last Cleaning ____________________

Last Exam Date ____________________

Date of your Last Full Series X-Rays ____________________

Last Cavity Detection(Bitewing) X-Rays ____________________

Do your Gums Bleed while Brushing or Flossing ? ☐

Are your teeth Sensitive to Hot, Cold or Sweets ? ☐

Do you get Frequent Fever Blisters, Mouth Ulcers or Sores on your Lips or in your Mouth ? ☐

Have you ever had Burning of the Tongue or Cracking of the Corners of your Mouth ? ☐

Do you Chew/Smoke Tobacco in any form ? ☐

Have you had any Head, Neck or Jaw injuries ? ☐

Do you Notice Popping, Clicking or Soreness of the Jaws or points just in front of the Ears ? ☐

Do you Clench or Grind your teeth ? ☐

Have you ever had Orthodontic Treatment ? ☐

If Yes Date of Placement ____________________

Do you wear Dentures or Partials ? ☐

If Yes Date of Placement of Dentures ? ____________________

Are you Happy with your Dentures ? ☐

Are you having any specific problems with your teeth, gums, or mouth at this time ? ☐

Are you Happy with your Smile? ☐

Do you have problems with teeth/fillings breaking ? ☐

Do you regularly use Dental floss ? ☐

Do you have ever been told you have Pyorrhea ? ☐

Do you have difficulty in opening your mouth widely ? ☐

Do you have an Unpleasent taste or Odor in your teeth ? ☐

Does food catch between your teeth ? ☐

Do you want to learn to control your dental disease and retain your teeth ? ☐

Additional Comments ____________________

Autism ☐

Medical Questionnaire

Medical Questionnaire

Family Physician ____________________

Phone ____________________

Are you currently under care of a Physician ? ☐

If Yes, What is the condition being treated ? ____________________

Have you had any Serious Illness, Operation or been Hospitalized within the past 5 years ? ☐

If Yes, what illness or Problem ____________________

Are you currently taking any Medication ? ☐

If Yes What ? ____________________

Have you ever taken the Diet Control Drug Fen-Phen ? ☐

Do you use Alcoholic Beverages ? ☐

Do you Smoke ? ☐

Women Only

Are you Pregnant? ☐

If Yes, what is your Due Date ? ____________________

Are you Currently Nursing ? ☐

Do you have Menstrual Period Problems ? ☐

Are you on Hormone Replacement Therapy ? ☐

Are you on Birth Control Pills/Fertility Drugs ? ☐

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list ____________________

Anemia ☐

By signing below, I certify that all of the above information is true to the best of my knowledge.

____________________ ____________________

Patient/Guardian Signature **Date**