**Clark, Delaney & Associates**

**Thank you for selecting our office!**

**Whom may we thank for referring you?_____**

**Is anyone from your immediate family already a patient in our office? _____**

**(703) 391-2600**
**1950 Roland-Clarke Place**
**Suite 420**
**Reston, VA 20191**

**Date _____**

**Responsible Party Information if different from patient**

**Patient Information**

| Name | Mr. Mrs. Ms. Dr. | |
|---|---|---|
| First | _____ | _____ |
| Middle Initial | _____ | _____ |
| Last | _____ | _____ |
| Social Security # | _____ | _____ |
| Birthday | _____ | _____ |
| Sex | _____ | _____ |
| Address | | |
| Street | _____ | _____ |
| City | _____ | _____ |
| State | _____ | _____ |
| Zip Code | _____ | _____ |
| Home Phone | _____ | _____ |
| Cell Phone | _____ | _____ |
| Emergency contact | _____ | _____ |
| Emergency phone | _____ | _____ |
| **E-MAIL** | _____ | _____ |

**Insurance Information: We will not bill your insurance unless the information below is COMPLETE**

| Insured's name | Mr. Mrs. Ms. Dr. | |
|---|---|---|
| First | _____ | _____ |
| Middle Initial | _____ | _____ |
| Last | _____ | _____ |
| | Single married divorced student | |
| Employer | _____ | |
| Employer address | _____ | |
| Work phone | _____ | |
| Insurance company | _____ | |
| Street | _____ | |
| City | _____ | |
| State | _____ | |
| Zip Code | _____ | |
| Group number | _____ | |
| Group name | _____ | |

**Dental Information**

Date of last exam _____
Work done _____
Current problem _____
Bleeding gums when you brush? _____
Sensitive teeth hot? _____
cold? _____
sweets? _____
Do you clench or grind? _____
How do you feel about the
appearance of your teeth? _____

## HEALTH QUESTIONNAIRE

**Please answer the following questions:**

Have you been hospitalized in the last two years? _____
Are you currently under a medical doctor's care? _____
What is your physician's name? _____
Address _____
Phone number _____
List any medications you have taken in the last two years _____
List any medications you are currently taking _____
List any medications you are allergic or sensitive to _____
Do you have chest pain or shortness of breath when walking? _____
Do your ankles swell during the day? _____
Do you use more than two pillows to sleep? _____
Have you lost or gained more than ten pounds in the last year?_____
Are you on special diet? _____
Do you have any disease or condition not listed? _____
Women Are you pregnant? _____
Are you nursing? _____
Are you on birth control drugs? _____

**WOMEN NOTE:** **Antibiotics, (such as Penicillin), may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.**

**Please check any of the following conditions you have:**

| | | | |
|---|---|---|---|
| Heart failure | _____ | Chronic cough/bronchitis | _____ |
| Heart disease/attack | _____ | Tuberculosis | _____ |
| Angina Pectoris | _____ | Asthma | _____ |
| Congenital heart disease | _____ | Hay fever | _____ |
| Heart murmur | _____ | Allergies or hives | _____ |
| High or low blood pressure | _____ | Sinus trouble | _____ |
| Arteriosclerosis | _____ | Radiation therapy | _____ |
| Mitral valve prolapsed | _____ | Chemotherapy | _____ |
| Artificial heart valve | _____ | Hepatitis A (infectious) | _____ |
| Heart pacemaker | _____ | Hepatitis B (serum) | _____ |
| Heart surgery | _____ | Jaundice | _____ |
| Rheumatic fever | _____ | Venereal disease | _____ |
| Cortisone medication | _____ | A.I.D.S. | _____ |
| Latex allergy | _____ | H.I.V. positive | _____ |
| Are you smoker? | _____ | Chronic fatigue/night sweats | _____ |
| Drug addiction | _____ | Cold sores/fever blisters | _____ |
| Stroke | _____ | Blood transfusion | _____ |
| Artificial Joints | _____ | Hemophilia/bleed easily | _____ |
| Kidney trouble | _____ | Anemia | _____ |
| Ulcers | _____ | Sickle cell disease | _____ |
| Diabetes/low blood sugar | _____ | Epilepsy or seizures | _____ |
| Thyroid problems | _____ | Fainting or dizzy spells | _____ |
| Glaucoma | _____ | Nervousness | _____ |
| Cancer | _____ | Tumors | _____ |
| Emphysema/lung problems | _____ | Developmentally disabled | _____ |
| Contagious diseases | _____ | Mental Health problems | _____ |

## PLEASE READ THE FOLLOWING CAREFULLY

1) I certify I have read, understand, and answered all appropriate items on the Patient Information/Health Questionnaire form to the best of my ability.
2) If I allow dental procedures to be performed on me I acknowledge that these procedures, their possible alternatives, and any risks have been explained to my satisfaction and consent to said procedures being performed.
3) **Payment, in full, is due upon the date of service unless other arrangement have been made. If we accept partial payment on the date of service because you are insured any outstanding balance will be due and payable within sixty days of the date of service.**
4) I hereby authorize my insurance carrier to issue payment directly to Clark, Delaney & Associates
5) I acknowledge receipt of Notice of Privacy Practices

**I hereby certify that I have read, fully understand, and agree with all of the above terms and conditions.**

**Name, (printed) _____Signature_____Date_____**