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_____