Woodbridge Smiles
14904 Jefferson Davis Hwy Ste # 304
Woodbridge , VA 22191
Phone : 703-910-4805
Fax : 703-910-7436

Confidential New Patient Information Form

Welcome to Woodbridge Smiles! By filling out this form in the comfort of your office or home we can be prepared for you when you first come to our office. If you have dental insurance then the information will allow us to print out the proper forms that you require for reimbursement from your insurance company. Once this form is filled out… bring it with you or fax it to us at 703-910-7436. Thanks for your time and for choosing Woodbridge Smiles.

Patient Address Information

Name _____

Birth date _____

Address _____

SSN # _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Employer Name _____

Employer Address _____

Whom may we thank for referring you to our practice? ☐ Patient ☐ Friend ☐ Relative ☐ Referring Dental Office
☐ Previous Patient ☐ Drive / Walk by ☐ School ☐ Work ☐ Woodbridge Dental Web Site ☐ Employee
☐ Yellow Pages ☐ Newspaper ☐ Name of referral _____

Responsible Party information – Check here if same as page 1 ☐

Name of Person responsible _____

Relationship_____ Birth Date _____ SSN # _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____

Insurance Information – will usually be on a card from your employer

Name of Insured #1 _____ Relationship _____

Insurance Carrier _____

Birth Date _____ SSN # _____

Group # - _____ Employee ID Number _____

Employer Name _____

Work Address _____

Do you have additional insurance? Yes ☐ No ☐ If yes, complete the following

Additional Insurance Information

Name of Insured #2 _____ Relationship _____

Insurance Carrier _____

Birth Date _____ SSN # _____

Group # - _____ Employee ID Number _____

Employer Name _____

Work Address _____

Emergency Contact Information

Name_____Phone _____ Relationship_____

Name_____Phone _____ Relationship_____

Health Information

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive.

Date of Last Dental Visit: _____ Reason for today's visit:_____

Have you ever had any of the following?

☐ AIDS/HIV	☐ Excessive Bleeding	☐ Liver Disease	☐ Tumors
☐ Allergies	☐ Fainting	☐ Mental Disorders	☐ Ulcers
☐ Epilepsy	☐ Glaucoma	☐ Nervous Disorders	☐ Venereal Disease
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Tuberculosis
☐ Arthritis	☐ Kidney Disease	☐ Radiation Treatment	☐ Tobacco use
☐ Artificial Joints	☐ Head Injuries	☐ Respiratory Problems	☐ Cold sores
☐ Asthma	☐ Heart Disease	☐ Rheumatic Fever	☐ Other:
☐ Blood Disease	☐ Heart Murmur	☐ Rheumatism	_____
☐ Cancer	☐ Hepatitis-A / B / C	☐ Sinus Problems	_____
☐ Diabetes-Type 1 or 2	☐ High Blood Pressure	☐ Stomach Problems	_____
☐ Dizziness	☐ Jaundice	☐ Stroke	

Are you presently taking any medications? If yes, please list.

☐ Antibiotics ☐ Anticoagulants ☐ Medicine for HBP ☐ Cortisone (Steroids) ☐ Aspirin ☐ Insulin ☐ Sulfa Drugs
☐ Digitals/Drugs for Heart trouble ☐ Nitroglycerin ☐ Fen-Phen (now or in the past) ☐ Tranquilizers
☐ Any other medications please list.

_____
_____

Are you allergic to or have had adverse reactions to any of the following?

☐ Penicillin or other antibiotics ☐ Local Anesthetic ☐ Latex ☐ Iodine ☐ Aspirin ☐ Metal ☐ Sulfa Drugs
☐ Any other medications please list.

_____
_____

Have you ever had any complications following dental treatment?
☐ Yes ☐ No If yes, please explain

_____

Have you ever been admitted to a hospital or been to emergency care in last 2 years? ☐ Yes ☐ No If yes, please explain

_____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:_____

Name of Physician_____ Phone:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

_____ _____
Signature of patient, parent or guardian Full Name