Arlington Center FOR DENTISTRY

TODAY'S DATE: _____

PATIENT INFORMATION

ALL INFORMATION ON THIS FORM MUST BE COMPLETED

NAME: _____
FIRST MIDDLE INITIAL LAST SUFFIX

ADDRESS: _____
NUMBER AND STREET APT. NO.

_____
CITY STATE ZIP CODE

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

PHONE: HOME _____ **E-MAIL:** _____

WORK _____

MOBILE _____ **GENDER:** ☐ MALE ☐ FEMALE

EMERGENCY CONTACT: _____
NAME PHONE RELATIONSHIP

MARITAL STATUS (PLEASE CIRCLE): SINGLE MARRIED DIVORCED WIDOWED

INSURANCE INFORMATION

PRIMARY DENTAL CARRIER

INSURANCE CO. _____ SUBSCRIBER NAME: _____

SSN / ID NO: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE CO. PHONE NO: _____ EMPLOYER: _____

SECONDARY DENTAL CARRIER

INSURANCE CO. _____ SUBSCRIBER NAME: _____

SSN / ID NO: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE CO. PHONE NO: _____ EMPLOYER: _____

MEDICAL CARRIER

INSURANCE CO. _____ SUBSCRIBER NAME: _____

SSN / ID NO: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE CO. PHONE NO: _____ EMPLOYER: _____

INSURANCE AUTHORIZATION

I hereby authorize release of information necessary to process my dental benefit claims and for payment otherwise payable to me to be made directly to Arlington Center for Dentistry. I understand that I am responsible for my portion of the approved fee as determined by my plan, and that payment is due at the time services are rendered.

_____ _____
PATIENT SIGNATURE DATE

OTHER INFORMATION

HOW DID YOU HEAR ABOUT US? _____

REASON FOR TODAY'S VISIT? _____

1050 N. HIGHLAND STREET SUITE 300-N ARLINGTON VA 22201 P: 703-527-3888 F: 703-527-6888 INFO@ACDSMILE.COM

MEDICAL HISTORY AND INFORMATION

CONDITIONS

Y	N		Y	N		Y	N	
☐	☐	ADHD	☐	☐	Hepatitis A B C (Please Specify)	☐	☐	Aspirin
☐	☐	Allergies (Seasonal)	☐	☐	Hormone Deficiency	☐	☐	Codeine
☐	☐	Anemia	☐	☐	High Blood Pressure	☐	☐	Dental Anesthetics
☐	☐	Angina	☐	☐	High Cholesterol	☐	☐	Erythromycin
☐	☐	Arthritis	☐	☐	Immunosuppresion	☐	☐	Iodine
☐	☐	Artificial Joint(s)	☐	☐	Kidney Disease	☐	☐	Latex
☐	☐	Asthma	☐	☐	Liver Disease	☐	☐	Metals
☐	☐	Blood Transfusion	☐	☐	Low Blood Pressure	☐	☐	Penicillin
☐	☐	Blood Disorder	☐	☐	Lung Disease	☐	☐	Sulfa
☐	☐	Cancer	☐	☐	Osteoporosis	☐	☐	Tetrcycline
☐	☐	Diabetes	☐	☐	Psychiatric Problems	Other: _____		
☐	☐	Drug / Alcohol Abuse	☐	☐	Rheumatic Fever			
☐	☐	Emphysema	☐	☐	Seizures			
☐	☐	Epilepsy / Fainting	☐	☐	STD / Venereal Disease	☐	☐	Do you use tobacco products?
☐	☐	Fever Blister	☐	☐	Shingles / Chicken Pox			
☐	☐	Headaches / Migraines	☐	☐	Sinus Problems	**FOR WOMEN**		
☐	☐	Gastrointestinal Problems	☐	☐	Speech / Hearing Impairment	☐	☐	Are you taking birth control pills?
☐	☐	Glaucoma	☐	☐	Stroke	☐	☐	Are you pregnant?
☐	☐	HIV / AIDS	☐	☐	Thyroid Problems			If yes, how many weeks _____
☐	☐	Heart Murmur	☐	☐	Tuberculosis	☐	☐	Are you nursing?
☐	☐	Heart Disease	Other: _____			☐	☐	Are you undergoing hormone therapy?

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

TREATMENT AUTHORIZATION

I authorize the Arlington Center for Dentistry dental team to perform dental services that I may need and have consented to during diagnosis and treatment, including the use of local anesthesia and other medication. I certify that the medical information provided on this page is current and accurate to the best of my knowledge.

_____ _____

PATIENT SIGNATURE DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

PATIENT SIGNATURE DATE

AUTHORIZATION TO RELEASE HEALTH INFORMATION

☐ I **DO NOT** authorize the practice to release my health information to anyone except for my insurance carrier.
☐ I authorize the practice to release my health information to the following parties in addition to my insurance carrier:

_____ _____ _____ _____

NAME (RELATIONSHIP) NAME (RELATIONSHIP)

_____ _____

PATIENT SIGNATURE DATE