WELCOME TO OUR PRACTICE

PATIENT INFORMATION...

Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age ____ Social Security Number _____

Street _____ Apt. ____ City _____ State _____ Zip _____

Home Tel.(____) _____ Cell.(____) _____ E-mail _____

Did you find our practice online? ❑ Yes ❑ No Referred By _____ (FIRST NAME) _____ (LAST NAME)

Have you ever been a patient of our practice? ❑ Yes ❑ No Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Medical Doctor _____ (FIRST NAME) _____ (LAST NAME)

Preferred Pharmacy _____ Tel. (____) _____

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(____) _____

Employer _____ Bus. Tel.(____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age ____ Tel.(____) _____

Street _____ Apt. ____ City _____ State _____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel.(____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. ____ City _____ State _____ Zip _____

Tel. (____) _____ Employer _____ Bus. Tel.(____) _____

INSURANCE INFORMATION...

Student: ..... ❑ Full Time ❑ Part Time ❑ Not ..... School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: .. ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: ..... ❑ Full Time ❑ Part Time ❑ Retired ❑ Not ..... Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY INSURANCE COMPANY...

Insurance Type: ❑ Dental ❑ Medical

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel.(____) _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel.(____) _____

SECONDARY INSURANCE COMPANY...

Insurance Type: ❑ Dental ❑ Medical

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel.(____) _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel.(____) _____

DENTAL INFORMATION...

Reason for today's visit _____ Are you in pain? ❑ Yes ❑ No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

- ❑ Discomfort, clicking, or popping in jaw
- ❑ Red, swollen, or bleeding gums
- ❑ A removable dental appliance
- ❑ Blisters / sores in or around the mouth
- ❑ Prolonged bleeding from an injury / extraction
- ❑ Recent infections or sore throat
- ❑ My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting
- ❑ Lost / broken filling(s)
- ❑ Teeth grinding / clenching
- ❑ Ringing in ears
- ❑ Broken / chipped tooth
- ❑ Gum disease
- ❑ Other _____
- ❑ Stained teeth
- ❑ Locking jaw
- ❑ Bad breath
- ❑ Burning tongue / lips
- ❑ Toothache
- ❑ Difficulty closing jaw
- ❑ Difficulty opening jaw
- ❑ Loose / shifting teeth
- ❑ Food caught between teeth
- ❑ Swelling / lumps in mouth

Last dental exam _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ❑ Yes ❑ No

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

MEDICAL HISTORY...

Are you in good health? ❑ Yes ❑ No • Height _____ Weight _____ • Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you ever had general anesthesia? ❑ Yes ❑ No • Have you, or a family member, had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Mental health problems	❑	❑	Abnormal bleeding	❑	❑	Kidney trouble
❑	❑	High blood pressure	❑	❑	Problems with immune system *(possibly from med. / surg.)*	❑	❑	Bleeding tendency	❑	❑	Sexually transmitted diseases
❑	❑	Low blood pressure	❑	❑	Delay in healing	❑	❑	Blood transfusion	❑	❑	Contagious diseases
❑	❑	Mitral valve prolapse	❑	❑	Hay fever / Sinus problems	❑	❑	Blood disorder	❑	❑	Infectious mononucleosis
❑	❑	Heart murmur	❑	❑	Snoring	❑	❑	Bruise easily	❑	❑	Swollen ankles
❑	❑	Chest pain / Angina	❑	❑	Sleep apnea / CPAP	❑	❑	Eye disease / Glaucoma	❑	❑	Arthritis / Joint disease
❑	❑	Heart attack(s)	❑	❑	Respiratory problems	❑	❑	Jaundice / Liver disease	❑	❑	Prosthetic implant
❑	❑	Irregular heart beat	❑	❑	Tuberculosis	❑	❑	Hepatitis	❑	❑	Joint replacement
❑	❑	Cardiac pacemaker	❑	❑	Emphysema	❑	❑	Gallbladder trouble	❑	❑	Osteoporosis / Osteopenia
❑	❑	Heart surgery	❑	❑	Do you smoke or vape? *If so, how much a day*_____	❑	❑	Fainting spells	❑	❑	Osteonecrosis
❑	❑	Damaged heart valves				❑	❑	Convulsions / Epilepsy	❑	❑	Stomach ulcers / Acid reflux
❑	❑	Pneumonia / Bronchitis / Chronic cough				❑	❑	Stroke	❑	❑	GI troubles / IBS / Colitis
❑	❑	Chronic fatigue / Night sweat	❑	❑	Do you use chewing tobacco	❑	❑	Thyroid trouble	❑	❑	Tumor or growth
❑	❑	Trouble climbing 1-2 flights of stairs	❑	❑	A history of marijuana or other drug use	❑	❑	Diabetes	❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Anemia				❑	❑	Low blood sugar	❑	❑	Are you on a diet
❑	❑	Asthma	❑	❑	A history of alcohol abuse	❑	❑	Are you on dialysis	❑	❑	Contact lenses

MEDICATION & ALLERGIES...

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
									❑	❑	Blood thinners (Coumadin, Aspirin, Eliquis, Xarelto)
									❑	❑	Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years?

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
❑	❑	Sodium pentothal / Valium / other tranq.	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	Do you have any known allergies

Please list any other medication or antibiotic you are allergic to: _____

Please list any allergies other than drug allergies: _____

1-4 below for women only: *(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.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

❑ I permit the office to communicate with me via text message on my cell phone.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

I hereby acknowledge that a copy of this office'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.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

SMILE ASSESSMENT FORM

Please consider each statement carefully and circle YES or NO. The doctor and members of the dental team will discuss your responses with you in confidence.

1. I am concerned about the appearance of my teeth or my smile.	YES	NO
2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth.	YES	NO
3. I am concerned about the position or angle of one or more of my teeth.	YES	NO
4. I am concerned about the shape of one or more of my teeth.	YES	NO
5. In social situations, I am sometimes embarrassed by my teeth or my smile.	YES	NO
6. There are some things about my upper front teeth that I would like to change.	YES	NO
7. There are some things about my lower front teeth that I would like to change.	YES	NO
8. I have old fillings or previous dental treatment that is no longer satisfactory to me.	YES	NO
9. I am missing one or more of my teeth.	YES	NO
10. I am interested in learning more about esthetic dentistry.	YES	NO

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank you.

Kenneth Van Stralen D.D.S. 3111 Telegraph Corner Lane Suite 201 Alexandria, VA 22310 (703) 317-3900 Fax (703) 317-3352

KENNETH M. VAN STRALEN, D.D.S.

3111 Telegraph Corner Lane Suite 201

Alexandria, VA 22310

APPOINTMENTS

A minimum charge may be made to failed or cancelled appointments without prior notification of 48 hours. This fee covers only a portion of the overhead, such as salaries, electricity, heat, etc./ which must be paid whether you are here or not. Once an appointment has been made, please remember that this time has been reserved for you.

PAYMENTS

Payment for dental services rendered is due at the time of treatment or as mutually agreed. If it becomes necessary to refer this account to an attorney for collection, I hereby agree to pay attorney fees in the amount of the third of the amount of the debt. I also agree to pay 1.5% per month (18% per annum) in interest on my unpaid balance after 60 days.

INSURANCE

To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payments of fees. We will prepare the necessary forms or reports to help you obtain benefits from your insurance company(ies).

PATIENT SIGNATURE_____DATE_____

Parent or Guardian if Patient is a Minor