GYURICZA & HARTMAN
FAMILY & COSMETIC DENTISTRY

PATIENT REGISTRATION

Phone: _____
Cell: _____

Date: _____ (PLEASE PRINT) Email: _____

Patient: _____
(Last Name) (First Name) (Initial) (Preferred Name)

Street Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: ____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse Name: _____ Spouse Birthdate: _____

Spouse Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Social Security Number: _____ Spouse's Social Security Number: _____

Dental Insurance Company: _____ Group Number: _____

In case of emergency, who should be notified? _____ Phone: _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Physical: _____

Have you ever had any of the following? (Check boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Heart Murmur-Mitral Valve Prolapse
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ "A.I.D.S" or Other Immunosuppressive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any **drug allergies** or have you ever had an **adverse reaction** to any medication? _____ If so, what:

_____

*BURKE PROFESSIONAL CENTER * 5212-B LYNGATE COURT * BURKE, VA 22015 * 703.978.5660. * FAX: 703.978.0423*
WWW.NORTHERNVIRGINIASMILES.COM

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what: _____

Are you under the care of a physician? ☐ Yes ☐No

For what conditions? _____

If the patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐No

Are you nursing? ☐ Yes ☐No

Is there anything else we should know about your medical history? _____

DENTAL HISTORY

Date of last dental exam? _____ Date of last full mouth series? _____

What is the reason for today's visit? _____

If there was a simple inexpensive way to whiten your teeth, would you be interested? _____

If you could wave a magic wand and change one thing about your smile, what would it be?_____

Why did you leave your last dentist? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have in the completion of this form.

Patient Name: _____ Signature: _____ Date: _____

*BURKE PROFESSIONAL CENTER * 5212-B LYNGATE COURT * BURKE, VA 22015 * 703.978.5660. * FAX: 703.978.0423*
WWW.NORTHERNVIRGINIASMILES.COM