Dr. Sarah Kennealy D.D.S
1451 Belle Haven Rd., Suite 310
Alexandria, VA 22307
P: 703-910-3182
F: 703-574-1088

PATIENT INFORMATION

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Nickname: _____

Address: Street_____City_____State_____Zip Code_____

Phone Number: _____ Work _____

Email: _____

Gender: ☐ M ☐ F ☐ Prefer not to specify

Birthdate: _____/_____/_____

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____ Phone: _____

How were you referred to our office? ☐ Web ☐ Insurance ☐ Other Doctor ☐ Friend/Family ☐ Other

INSURANCE INFORMATION

Insurance Information:

Insurance Carrier (Company): _____

Policy holder: _____

Policy holder date of birth: _____

PHARMACY INFORMATION

Name of Pharmacy: _____

Phone number: _____

Address:_____

_____

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DENTAL HISTORY

Dental History:

When was your last dental exam?

Date: _____

When was your last dental X-ray?

Date: _____

How often do you brush? #times/day_____ How often do you floss? #times/day_____

Do you grind your teeth? □ YES □ NO

Have you ever had orthodontic (braces) treatment? □ YES □ NO

Have you ever had periodontal (gum) treatment? □YES □NO

Do you have any of the following:

□Bad Breath	□Dry Mouth	□Partials	□Mouth Sores
□Bleeding Gums	□Difficulty Chewing	□Sensitivity to cold	□Difficulty opening and closing mouth
□Blister on Mouth	□Ear pain	□Sensitivity to heat	
□Broken Fillings	□Jaw Pain	□ Sensitivity to sweets	
□ Clicking Jaw	□ Loose Teeth	□ Sensitivity to pressure	
□Dentures	□Mouth pain	□ Swollen gums	

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MEDICAL HISTORY

Are you under the care of a Physician? Yes___ No ___ Name: _____

Current medications or drugs? Yes ___ No ___ Name/Dosage: _____

Are there any Drug/Food/metal/latex allergies? Yes__ No __ If yes, please describe: _____

Have you had any history of?

□Anemia	□Cerebral Palsy	□Heart Disease	□Problems with Anesthesia
□ Asthma	□ Convulsions	□Heart Murmur	□Seasonal Allergies
□ Autism	□ Developmental Delay	□Hearing Problems	□Tuberculosis
□ADHD	□ Diabetes	□Hepatitis/Liver Disease	
□AIDS/HIV	□ Down Syndrome	□High/Low Blood Pressure	
□Blood Disorder	□Epilepsy	□Kidney Disease	
□Cancer	□Ear,eye,nose trouble	□ Lung Disease	

If yes, please describe: _____

LIFESTYLE FACTORS

Have you ever smoked?

☐ Yes ☐ No # of Years _____ # of Packs/ day _____

Do you smoke now?

☐ Yes ☐ No # of Years _____ # of Packs/ day _____

Do you use recreational drugs?

☐ Yes ☐ No Types? _____ # times/ week _____

How much alcohol do you drink per week?

drinks/ week:

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WOMEN ONLY

Are you pregnant?

□YES □NO

Are you breastfeeding?

□YES □NO

If answered yes, When is your due date? _____

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

Patient's / Guardian's Signature **Date**

Print Name _____