



Jaklin Bezik, DDS, MDS
Periodontics & Implant Dentistry

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Patient Information

Name _____ Birthdate: _____
First MI Last
Address: _____ City _____ State _____ Zip _____
SS# _____ Status _____ Home phone# _____
Work phone # _____ Cell phone _____ Email _____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone# _____

Responsible Party

Name of subscriber of the dental policy _____
First MI Last
Relationship to patient _____ Subscriber SS# _____ DOB _____
Employer phone # _____ Employer Name _____

Insurance Information

Name of Insurance Company _____ Policy ID# _____
Group ID# _____ Insurance phone # _____
Insurance address: _____
Address City State Zip Code

Dental History

General Dentist _____ Phone # _____
Physician Name _____ Phone# _____
Reason for today's visit _____
Date of last exam _____ Date of last dental X-rays _____
How often do you brush? _____ How often do you floss? _____
You would best describe your general health as : GOOD FAIR POOR
Are you under the care of regular physician? _____ If yes, what is the condition? _____
Please indicate any major hospitalization/operation or illness _____
Do you need to be pre-medicated before dental procedure? _____
Do you feel apprehensive when you are having dental treatment? _____

Please check any of the following conditions that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to hot/sweet |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Biting your cheek |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths |

Medical History

Women Only: Are you pregnant? Yes No, Nursing? Yes No

Taking birth control pills? Yes No

Do you have a history of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Steroid treatment | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> STD | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respirator Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tobacco Habit | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Problem | <input type="checkbox"/> Heart Attack |

Does anyone in your immediate family have a history of the above conditions?

If yes, please explain.

Please list all medications you are currently taking: _____

Allergies: _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
SIGNATURE OF PATIENT (or parent if a minor) DATE