

# Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.  
If you have any questions or need assistance, please ask us and we will be happy to help.

## Dr. Dunne & Staff

### Patient Information (Confidential)

Name \_\_\_\_\_ Date \_\_\_\_\_

Gender \_\_\_\_\_ Male / Female (Please Circle) EMAIL \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

### Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard

Co-payments are due when services are rendered.

### Insurance information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of Employer \_\_\_\_\_

Do You Have Any Additional Insurance? ☐ Yes ☐ No If so, please provide insurance card to staff.

Over Please

# Patient Medical History

Physician _____	Office Phone _____	Date of Last Exam _____
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<p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what medication(s) are you taking? _____</p> <p>4. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you have or have you had any of the following?</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </td> <td style="width: 50%;"> <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Troubles / Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </td> </tr> </table>	<p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Troubles / Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>8. Are you allergic to or have you had any reactions to the following: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Local Anesthetics (e.g. novocain) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any Metals (e.g. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex Rubber <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Women Only:</p> <p>a) Are you pregnant or think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"> <p>Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay Fever / Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </td> <td style="width: 50%;"></td> </tr> </table>	<p>Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay Fever / Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
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# Patient Dental History

Name of Previous Dentist _____	Date of Last Exam _____
Previous Dentist's Location _____	Date of Last Cleaning _____

<p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel pain to any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you had any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever experienced any of the following problems in your jaw?</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"> <p>Clicking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain (joint, ear, side of face) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in opening or closing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in chewing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </td> <td style="width: 50%;"></td> </tr> </table>	<p>Clicking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain (joint, ear, side of face) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in opening or closing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in chewing <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>8. Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever had any difficult extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of placement _____</p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Clicking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain (joint, ear, side of face) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in opening or closing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in chewing <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			

# Authorization and Release

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 payors and/or health practitioners. I authorize and request my insurance company to pay

directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

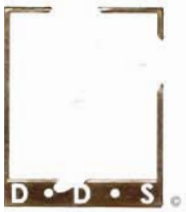
Signature of patient (or parent if minor)

Doctor's Comments \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_





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## FRANK J. DUNNE, D.D.S., P.C.

General & Cosmetic Dentistry

11872 Sunrise Valley Dr., Suite 100

Reston, Virginia 20191

(703) 390-1100 • Fax: (703) 390-1108

### OUR POLICY OF CARE AND PAYMENT

Frank J. Dunne, D.D.S.

*Dr. Dunne & Staff strive to make your dental health their top priority.  
The goal of their dental practice is to ensure that their patients receive high quality  
care in a comfortable and caring environment.*

Co-Payment is due at the time of treatment. We also have a payment plan called **CareCredit** that allows you to start treatment today and spread payments over time without interest. Applying for **CareCredit** only takes a few minutes and there is no fee to apply.

### PAYMENT OPTIONS

- 1.) Cash or Check
- 2.) Visa, Mastercard & Discover
- 3.) CareCredit

**\* A FEE MAY BE CHARGED FOR BROKEN APPOINTMENTS  
CANCELLED WITH LESS THAN 48 HOUR NOTICE.**

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date

\*Charges may vary depending on the amount of time reserved for the scheduled appointment.

*Thank you.*