Wendy M. Moore, DDS

9449 Grover Drive, Suite 100
King George, VA 22485

Tele: (540) 775-5774
Fax: (540) 775-6538
Email:
drwendy@wendymooredds.com
Web: www.wendymooredds.com

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender: ☐ Male ☐ Female ☐ Other ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ E-Mail Address: _____

Phone Home: _____ Work: _____ Cell: _____

Mailing Address: _____
Street or PO Box Apartment #

_____
City State Zip Code

Street Address: _____
(if different from above) Street Apartment #

_____
City State Zip Code

Person to contact in case of emergency: _____ Phone: _____

Responsible Party Information

Check here if the same as above ☐

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____ E-Mail: _____

Phone Home: _____ Work: _____ Cell: _____

Mailing Address: _____
Street or PO Box Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ Patient ☐ Parent/Guardian

Employer Name: _____ Occupation: _____

Address: _____
Street Suite #

_____
City State Zip Code

Referral Information

Who may we thank for referring you to our practice? ☐ Another patient ☐ Dental Office

If so, the name of person or office referring you to our practice: _____

☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Our Website ☐ Facebook ☐ Internet ☐ Other:_____

Patient Name: _____ Date: _____

Primary Insurance Information

Name of Subscriber: _____ Birth Date: _____
Last First MI

Subscriber's Social Security #: _____ Is the insured a current patient? ☐ Yes ☐ No

Subscriber's Mailing Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Company: _____ ID #: _____ Group #:_____

Insurance Plan Address:_____
Street City State Zip Code

Insurance Phone #:_____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance Information

Name of Subscriber: _____ Birth Date: _____
Last First MI

Subscriber's Social Security #: _____ Is the insured a current patient? ☐ Yes ☐ No

Subscriber's Mailing Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Company: _____ ID #: _____ Group #:_____

Insurance Plan Address:_____
Street City State Zip Code

Insurance Phone #:_____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Parent Authorization to Treat a Minor

I allow my child to receive treatment from the Doctor and the staff. I allow my child to have the appropriate x-rays taken and fluoride treatment given.

_____ _____
Parent/Guardian Signature Date

Authorization for Testing

Any patient who exposes a health care provider or his/her employee/agent to body fluid in any manner which may transmit the Hepatitis B or C virus or the human immunodeficiency virus (HIV) is deemed to have

consented to Hepatitis B, C and HIV testing and disclosure of the results to the person exposed. The deemed consent also applies to a health care provider who exposes a patient to body fluids in the above stated manner.

If an employee is exposed to my bodily fluid in any way that will transmit disease I agree to be tested. The caregiver also agrees to be tested if exposure occurs in any manner that may transmit disease to the patient.

_____ _____

Patient/Guardian Signature Date ___

Patient Name: _____ Date: _____

Dental History

Former Dentist: _____
Reason for today's visit: _____
Date of last exam: _____ Date of last dental X-rays: _____
Have you ever been diagnosed with Periodontal Disease? _____ When? _____
Is there an immediate family member(s) who currently has or had gum problems in the past? (E.g. Your mother, father, or siblings): ☐ Yes ☐ No
Have you noticed any of the following signs of gum disease?

☐ Pus between the teeth and gums
☐ Bleeding gums during brushing
☐ Loose or separating teeth
☐ Red, swollen or tender gums
☐ Change in the way your teeth fit together
☐ Gums that have pulled away from the teeth
☐ Food catching between the teeth
☐ Persistent bad breath

Is it important to keep your teeth for as long as possible? _____
If you have missing teeth; why have you not replaced them? _____
Do you now or have you ever used tobacco or other types of products: ☐ Yes ☐ No
If so, type:_____ Amount per Day:_____ Years used?:_____When did you quit?:_____
Have you returned from a foreign country in the last 30 days?: ☐ Yes ☐ No
If yes, are you feeling flu like symptoms?: ☐ Yes ☐ No

It's Your Smile

Have you ever had braces? ☐ Yes ☐ No
Do you wear a sports or night guard? ☐ Yes ☐ No
Are you pleased with the appearance of your smile? ☐ Yes ☐ No
If not, what would you like to change? _____
Are you pleased with their function? ☐ Yes ☐ No
Are your teeth yellow? ☐ Yes ☐ No
Do you sip something throughout the day? ☐ Coffee ☐ Tea ☐ Soda ☐ Juice ☐ Other:_____
Do you have any allergies to jewelry? ☐ Yes ☐ No
Do you use an electric toothbrush? ☐ Yes ☐ No
Are you under a lot of stress? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No ☐ Don't know

If so, do you wear a snore guard? ☐ Yes ☐ No If yes, was it custom made? ☐ Yes ☐ No

Authorization for Photographs

I, (please print) _____, give Dr. Wendy M. Moore, DDS permission to record my image and grant Dr. Wendy M. Moore, DDS all rights to use these photographs in any medium for educational, promotional, advertising, or other purposes that support the promotion of dentistry.

I Understand the above and agree to its terms.

_____ _____

Patient/Guardian Signature Date

Patient Name: _____ Date: _____

Health Information

- Are you currently taking any medications or vitamins? ☐ Yes ☐ No

If yes, please list all that you are taking:_____

- Have you had Oral and/or IV treatment with BISPHOSPHONATE (i.e. Fosamax, Actonel, etc.)? ☐ Yes ☐ No
- Do you need to be Pre-medicated (i.e. Heart, replacement of hip, knee, etc.)? ☐ Yes ☐ No

If yes, please check the medication you are traditionally pre-medicated with:

☐ Amoxicillin 500 mg ☐ Clindamycin 150 mg ☐ Cephalexin 500 mg ☐ Other:_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

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

If yes, please explain: _____

- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had any of the following? Please check all that apply:

☐ Acid Reflux	☐ Blood Clots	☐ Head Injuries	☐ Psychiatric Care
☐ AIDs	☐ Blood Disease	☐ Heart Disease	☐ Recreational Drug Use
☐ Allergies: ☐ Seasonal ☐ Aspirin ☐ Codeine	☐ Blood Problems	☐ Heart Murmur	☐ Radiation Treatment
	☐ Blood Thinners	☐ Hepatitis A, B, C or D	☐ Respiratory Problems
	☐ Bruise Easily	☐ High Blood Pressure My Normal BP_____/_____	☐ Rheumatism
	Cancer		Scarlet Fever

☐ Penicillin ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Sulfa ☐ Jewelry ☐ Other:	☐ Chemo TX	☐ HIV	☐ Seizures
	☐ Circulatory Problems	☐ Irregular Heart Beat	☐ Shortness of Breath
	☐ Cold Sores	☐ IV Medications	☐ Sinus Problems
	☐ Cortisone Injections	☐ Jaundice	☐ Sleep Apnea
	☐ Diabetes	☐ Kidney Problems	☐ Snoring
	☐ Emphysema	☐ Liver Problems	☐ Stroke
	☐ Excessive Bleeding	☐ Low Blood Pressure My Normal BP_____/_____	☐ Thyroid Problems
☐ Anemia	☐ Fainting		☐ Tobacco Habit
☐ Arthritis	☐ Fen-Phen Use	☐ Mental Disorders	☐ Tuberculosis
☐ Artificial Heart Valve	☐ Fever Blisters	☐ Migraines	☐ Tumors
☐ Artificial Joints	☐ Fibromyalgia	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Asthma	☐ Glaucoma	☐ Osteopenia	☐ Venereal Disease
☐ Back Problems	☐ Growths	☐ Osteoporosis	☐ Other:
☐ Bisphosphonate	☐ Hay Fever	☐ Pacemaker	☐ Are you pregnant?

Please list any additional information that you would like to disclose:

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____

Patient/Guardian Signature Date