Friendly Smiles Dental Care
Navdeep Aulakh DDS

9000 Fern Park Drive, Unit A2
Burke, VA 22015 Tel: (703)463-9817

Thank You for Selecting Us to Care for Your Comprehensive Dental Needs

In order to provide the best possible care, we need you to fill out this form completely in ink. If you have questions or problems, do not hesitate to call us, or ask us for help.

Patient Information (Confidential) Patient Number_____

Name_____Date _____

Gender_____ Male / Female (Please Circle) Email Address _____

Soc. Sec. #_____ Birth date_____ Home Phone _____

Address_____City_____ State___ Zip_____

Check Appropriate Box ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

If Student, Name of School/College_____ City_____ State _____ ☐Full Time ☐Part Time

Patient's or Parent's Employeer_____Work Phone_____

Business Address_____ City_____ State___ Zip_____

Spouse or Parent's Name_____ Employer_____Work Phone_____

Business Address_____City_____ State___ Zip_____

Whom May We Thank for Referring You?_____

Person to Contact in Case of Emergency_____

Responsible Party

Name of Person Responsible for this Account_____Relationship to Patient_____

Addresss_____Home Phone _____

Employer_____Work Phone_____SS#_____

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

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birth date_____ Social Security #_____ Date Employed_____

Employer Address_____City_____State____ Zip_____

Insurance Company_____ Group #_____ Policy/ID#_____

Ins. Co. Address_____City_____State____
Zip_____

How Much is Your Deductible?_____ How Much Have You Used?_____ Max. Annual Benefit_____

Do You Have Any Additional Insurance? ☐Yes ☐No If Yes, Complete the Following

Name of Insured_____ Relationship to Patient_____

Birth date_____ Social Security #_____ Date Employed_____

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Employer Address_____City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Policy/ID#_____

Ins. Co. Address_____ City_____ State_____ Zip_____

How Much is Your Deductible?_____ How Much Have You Used?_____ Max. Annual Benefit_____

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

1. Are you under medical treatment now? ☐Yes ☐No

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐Yes ☐No
If yes please
explain._____

3. Are you taking any medications including non-prescription medicine? ☐Yes ☐No
If yes, what medication(s) are you taking?
_____

4. Have you ever taken Phen/Fen/Redux? ☐Yes ☐No 5. Do you use tobacco? ☐Yes ☐No

6. Do you use controlled substances? ☐Yes ☐No 7. Do you have or have you had any of the following?

High Blood Pressure	☐Yes	☐No	Heart Disease	☐Yes	☐No	Chest Pains	☐Yes	☐No
Heart Attack	☐Yes	☐No	Cardiac Pacemaker	☐Yes	☐No	Easily Winded	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Stroke	☐Yes	☐No
Swollen Ankles	☐Yes	☐No	Angina	☐Yes	☐No	Hay Fever/Allergies	☐Yes	☐No
Fainting/Seizures	☐Yes	☐No	Frequently Tired	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Asthma	☐Yes	☐No	Anemia	☐Yes	☐No	Radiation Therapy	☐Yes	☐No
Low Blood Pressure	☐Yes	☐No	Emphysema	☐Yes	☐No	Glaucoma	☐Yes	☐No
Epilepsy/Convulsions	☐Yes	☐No	Cancer	☐Yes	☐No	Recent Weight Loss	☐Yes	☐No
Leukemia	☐Yes	☐No	Arthritis	☐Yes	☐No	Liver Disease	☐Yes	☐No
Diabetes	☐Yes	☐No	Joint Replacement or Implant	☐Yes	☐No	Heart Trouble	☐Yes	☐No
Kidney Diseases	☐Yes	☐No	Hepatitis/Jaundice	☐Yes	☐No	Respiratory Problems	☐Yes	☐No
AIDS or HIV Infection	☐Yes	☐No	Sexually Transmitted Disease	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No
Thyroid Problem	☐Yes	☐No	Stomach Troubles/Ulcers	☐Yes	☐No	Other_____	☐Yes	☐No

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8. Are you allergic to or have you had reactions to the following?

Local Anesthetics (e.g. Novocain)	☐Yes	☐No	Penicillin or other Antibiotics	☐Yes	☐No
Sulfa Drugs	☐Yes	☐No	Barbiturates	☐Yes	☐No
Sedatives	☐Yes	☐No	Iodine	☐Yes	☐No
Aspirin	☐Yes	☐No	Any metals (e.g. nickel, mercury, etc.)	☐Yes	☐No
Latex Rubber	☐Yes	☐No	Other_____	☐Yes	☐No

9. Women Only:

a. Are you pregnant or think you may be pregnant? ☐Yes ☐No

b. Are you nursing? ☐Yes ☐No

c. Are you taking oral contraceptives? ☐Yes ☐No

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam_____

Previous Dentist's Location _____ Date of Last Cleaning_____

1. Do your gums bleed while brushing or flossing?	☐Yes	☐No	2. Are your teeth sensitive to hot or cold liquids/foods?	☐Yes	☐No
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐Yes	☐No	4. Do you feel pain to any of your teeth?	☐Yes	☐No
5. Do you have any sores or lumps in or near your mouth?	☐Yes	☐No	6. Have you had any head, neck or jaw injuries?	☐Yes	☐No
7. Have you ever experienced any of the following problems in your jaw?					
Clicking	☐Yes	☐No	Pain (joint, ear, side of face)	☐Yes	☐No
Difficulty in opening or closing	☐Yes	☐No	Difficulty in chewing	☐Yes	☐No
8. Do you clench or grind your teeth?	☐Yes	☐No	9. Have you ever had any difficulty extractions in the past?	☐Yes	☐No
10. Have you ever had any prolonged bleeding following extractions?	☐Yes	☐No	11. Have you had any orthodontic treatment?	☐Yes	☐No

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 diagnosis and the records of any treatment or examination rendered to me and/or my child during the period of such Dental care to third party 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)