Vienna Periodontics and Implant Surgery

NEW PATIENT INFORMATION

301 Maple Ave W, Suite 440
Vienna, VA 22180
Telephone: (703) 539-9166
Email: info@viennaperio.com

About You

Today's Date: ______ / ______ / ______ Gender: M F Birthday: ______ / _______ / _________

Referred by: ____ Referred for: ____

First Name: ____ Last Name: ____

Home Address: ____

City: ____ State: _________ Marital Status: ____________________

Home Phone: (____) ______ - ______ Cell Phone: (____) ______ - ______ Work Phone: (____) ______ - ______

Email address: ____

Employer: ____Occupation : ____

Other family members seen by us?

Family Friends Other: ____

Spouse Information

First Name: ____ Last Name: ____

Birthday: ______ / _______ / _________ Work Phone: (____) ______ - ______

Home Address: ____

City: ____ State: _________

Employer: ____Occupation : ____

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Primary Insurance

Insurance Company: ____

Claims Address: ______________________ **City:** ______________ **State:** _______

Insurance Co. Phone: (____) ______ - ______ **Group Number:** ______________________

Name of Insured: ______________________ **Relationship to Patient:** ______________________

Social Security Number of Insured : ______ / _______ / _________

Name of Insured's Employer: ____

Secondary Insurance

Secondary Insurance: ____

Insurance Company: ____

Claims Address: ______________________ **City:** ______________ **State:** _______

Insurance Co. Phone: (____) ______ - ______ **Group Number:** ______________________

Name of Insured: ______________________ **Relationship to Patient:** ______________________

Birth Date of insured: ______ / ______ / ______ **Name of insured's Employer:** ______________________

In Case of Emergency

PLEASE PROVIDE THE FOLLOWING FOR A FRIEND OR RELATIVE NOT LIVING WITH YOU

First Name: ______________________ **Last Name:** ______________________

Relationship to You: ______________ **Home Phone:** (____) ______ - ______ **Work Phone:** (____) ______ - ______

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Medical History

Name of Physician: ______________________________ **Phone Number:** (___) _____ - _____

DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THOSE THAT APPLY:

- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints*
- ☐ Artificial Heart Valves*
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Fever Blisters/Cold Sores
- ☐ Frequent Cough
- ☐ Glaucoma
- ☐ Heart Disorder (Congenital)
- ☐ Heart Infection*
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Surgery*
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV*/AIDS
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- Osteoporosis
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Surgical Shunt*
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

* This condition may require antibiotic premedication for certain dental procedures.

YES NO **Do you have any health problems that were not listed above or need further clarifications?**
If yes, explain: ______________________________

YES NO **Are you now under the care of a physician?**
If yes, explain: ______________________________

YES NO **Have you been admitted to a hospital or needed emergency care during the past two years?**
If yes, explain: ______________________________

YES NO **Are you taking any medications or herbals?**
If yes, list: ______________________________

YES NO **Are you allergic to any medications or substances?**
If yes, please check box below:
Aspirin Penicillin Codeine Iodine Metal Latex Other

YES NO **Have you used tobacco?**
If yes, explain: ______________________________

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Medical History Continued

Name of Physician: ____ **Phone Number:** (____) ______ - ______

DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THOSE THAT APPLY:

WOMEN (Please check): ☐ **Pregnant** ☐ **Trying to get pregnant** ☐ **Nursing** ☐ **Taking oral contraceptives**

Antibiotics that have been shown to interact with birth control pills include rifampin (Rifadin®), and to a lesser extent, amoxicillin, Bactrim®, tetracycline, minocycline, metronidazole (Flagyl®) and nitrofurantoin (Macrobid® or Macrodantin®).

I acknowledge that to the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

____ **Date :** ______ / ______ / ______

Signature

Authorization and Consent

General Consent to Treatment

☐ I agree and consent to a dental examination by Dr. Eunseok Eugene Oh, Anthony Palumbo or Emily Eunyoung Kim. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

☐ I authorize Dr. Eunseok Eugene Oh, Anthony Palumbo or Emily Eunyoung Kim to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

☐ I authorize and request my insurance company to pay my benefits directly to Dr. Eunseok Eugene Oh, Anthony Palumbo or Emily Eunyoung Kim.

Photography Release

☐ I authorize Dr. Eunseok Eugene Oh, Anthony Palumbo or Emily Eunyoung Kim to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options.

I understand and will comply with office Appointment Policy.
I understand and will comply with the office Financial Policy.
I understand and agree to the General Consent to Treatment.
I authorize the Release of Information.
I authorize Photographs to be taken of me and shown to other patients.

I acknowledge that to the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

____ **Date :** ______ / ______ / ______

Signature