2 West Loudoun Street Round Hill, VA 20141
Phone: (540) 338-0046
www.roundhillsmiledesign.com

General Information

Full Name_____

Address_____City _____

State _____ Zip _____ Home Phone (_____)_____

Cell Phone (____)_____ Best way to contact you? email call text

Date of Birth _____/_____/_____ Social Security Number_____

Email _____

Emergency Contact _____ Relation_____
Phone _____

How did you hear about us? _____

Dental Insurance

Policy Holder's employer _____

Relationship to patient _____

_____ ___/___/_____ _____
Full Name of Insured Employee Date of Birth Social Security Number

_____ _____
Insurance Company Subscriber Number

_____
Insurance Company Mailing Address

Medical History

Physician's Name _____ Phone Number _____

Please list any medications you are taking _____

_____

Are you allergic to any medication? _____

_____

Do you need to **Premedicate** prior to dental treatment? _____

_____

Allergies	Y	N
Heart Condition	Y	N
Surgery (please specify type)	Y	N
Joint Replacement	Y	N
Cancer (If yes, please specify)	Y	N
Diabetes	Y	N
Kidney/Bladder disease	Y	N
Asthma	Y	N
tuberculosis	Y	N
Stroke	Y	N
High Blood Pressure	Y	N

Latex Sensitivity	Y	N
hearing or Vision Problems	Y	N
Hepatitis, Cirrhosis, liver disease	Y	N
Epilepsy or Seizures	Y	N
Fainting or Dizzy Spells	Y	N
Blood Transfusion	Y	N
Abnormal Bleeding tendencies	Y	N
HIV or AIDS	Y	N
Sickle Cell Disease or Trait	Y	N
Stomach or Intenstinal Ulcers	Y	N
Chemo or Radiation Treatment	Y	N

Date of last dental visit _____ X-rays _____

Are you interested in Invisalign? _____

Have you had previous Orthodontic Treatment? _____

Have you ever been treated for gum disease? _____

Are you apprehensive about dental treatment? _____

Are you satisfied with the appearance of your teeth? _____

Is there anything you would change about your smile? _____

My signature acknowledges that the questions have been answered truthfully and completely.

Patient Signature_____Date_____