MT Dental Partners

Washington, DC · Alexandria, VA

Name: Mr. Mrs. Ms. Dr. (Other) _____

Address:_____City _____State ____Zip _____

Phone: Home _____ Work _____ Cell _____
(Please circle the best way to contact you.)
Email Address: _____ Spouse's name: _____

Social Security Number: _____ Date of Birth: _____

Employed by: _____ Occupation: _____

Business Address: _____

In case of emergency who should we notify? Name: _____ Phone: _____
Whom may we thank for referring you? _____
Special interests, sports, hobbies, etc.? _____
Do you have dental insurance? _____ **please note we are a fee for service practice**

MEDICAL HISTORY

Name and Address of your Physician: _____
Physician Phone: _____ Date of last complete exam: _____
Have you been hospitalized in the last 2 years? _____

Do you have or have you had any of the following? (Please circle and date)

Abnormal Heart Problems	Diabetes (type _____)	Kidney Disease	Sickle Cell
Abnormal Blood Pressure	Dialysis	Liver Disease	Sinus Problems
AIDS or HIV positive	Drug Abuse	Measles	STD
Anemia	Dry Mouth	Mitral Valve Prolapse	Stomach Ulcers
Arthritis (type_____)	Easy Bruising	Mumps	Stroke
Artificial Heart Valves	Emphysema	Nasal Obstruction	Substance Abuse
Asthma	Epilepsy	Neurologic Disorder	Tattoos & Body Piercing
Bulimia Nervosa	Gastritis	Osteoporosis	Thyroid Disorder
Blood Transfusions	GERD/Reflux	Persistent Cough	Tonsillitis
Cancer (type_____)	Gout	Psychiatric Care	Transplant Surgery
Cardiac Pacemaker	Heart Attack	Radiation Treatment	Tuberculosis
Circulatory problems	Heart Murmur	Rheumatic Fever	
Congenital Heart Disease	Joint Replacement		

Are you allergic to: Penicillin ____ Codeine ____ Local Anesthetics _____ Latex ____ Sulfa Drugs_____
Please list any other allergies: _____
List all medication &/or herbal supplements are you taking?

Women: Are you pregnant? _____ Nursing? _____

Consent for services

If I carry dental insurance, I understand that all dental services furnished are charged directly to me and that I am personally responsible for payment of all dental services. I understand that balances over 90 days will be charged 1.5% per month (18% per annum) interest. Also if my account is turned over to a collection agency, a delinquency fee of 20% of the unpaid balance will be added to my account. I give permission to you or your assignee to telephone me at home and/or at work to discuss matters relating too this balance. I have read the above conditions of treatment and agree to their content.

Signature of Patient or Guardian _____ Date: _____

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