Charles Curt Fischer D.D.S. F.A.G.D.
Katherine B. Fischer D.D.S. F.A.G.D.

5895 Trinity Parkway, Suite 200
Centreville, VA 20120 703-818-1500

Patient Registration and Health History

Patient_____(First, M.I. Last) Home Phone_____

Address_____City_____State____Zip_____

Sex:____M____F Birth date_____ Social Security #_____ E-Mail_____

Dental History

What is the reason for your visit today?_____
Date of Last Dental Visit _____Last Dental Cleaning _____Last Full Mouth X-Rays_____
How often do have dental examinations?_____
How often do you brush your teeth? _____How often do you floss? _____
What other dental aids do you use? (Toothpick, mouth rinse, etc.) _____
Do you have any dental problems now? Yes No
If yes, please describe_____

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or chewing	Yes	No
Do your gums bleed or hurt?	Yes	No
Do you have any loose teeth?	Yes	No
Do you smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Gum treatment?	Yes	No
Bite adjustments?	Yes	No
Bite plate or splint?	Yes	No
Serious mouth injury?	Yes	No

Do you;

Notice mouth odors or bad tastes?	Yes	No	Get food caught around teeth?	Yes	No
Frequently get mouth sores?	Yes	No	Clench or grind your teeth?	Yes	No
Mouth breathe?	Yes	No	Have tired jaws?	Yes	No

Have you experienced:

Clicking or popping of the jaw?	Yes	No	Difficulty in opening or closing?	Yes	No
Pain? (joint, ear, side of face)	Yes	No	Difficulty in chewing?	Yes	No

Do you feel nervous about having dental treatment? Yes No
Have you ever had an upsetting dental experience? Yes No
Overall, how would you evaluate your past dental treatment and experiences?
Excellent Good Fair Poor
Overall, how pleased are you with the appearance of your teeth and smile?
Extremely Pleased Moderately Pleased Satisfied Dissatisfied

Medical History

1. Have you been under the care of a physician during the past two years? Yes No
   If yes, for what?_____
   Physician's name_____Phone_____
   Address_____City_____State_____Zip_____
2. Are you taking any medication, including non-prescription, now?
   If yes, please list_____

(please complete other side)

3. List any allergies to drugs or substances_____

4. Indicate which of the following you have had, or have at present.

Heart (Surgery, Disease, Attack)	Yes	No	Asthma	Yes	No
Chest Pain	Yes	No	Latex Sensitivity	Yes	No
Congenital Heart Disease	Yes	No	Sinus Problems	Yes	No
Heart Murmur	Yes	No	Radiation Therapy	Yes	No
High Blood Pressure	Yes	No	Chemotherapy	Yes	No
Mitral Valve Prolapse	Yes	No	Cancer	Yes	No
Artificial Heart Valve	Yes	No	Thyroid Problems	Yes	No
Rheumatic Fever	Yes	No	Venereal Disease	Yes	No
Arthritis/Rheumatism	Yes	No	A.I.D.S. or HIV Infection	Yes	No
Cortisone/Steroid Medicine	Yes	No	Prolonged Bleeding	Yes	No
Stroke	Yes	No	Neurological disorders	Yes	No
Artificial Joints	Yes	No	Epilepsy or Seizures	Yes	No
Hepatitis, Jaundice, Liver Disease	Yes	No	Fainting or Dizzy Spells	Yes	No
Kidney Disease	Yes	No	Nervous/Anxious	Yes	No
Ulcers	Yes	No	Psychiatric Care	Yes	No
Diabetes	Yes	No	Chemical Dependency	Yes	No

5. Do you have any disease, condition, or problem not listed?
   If yes, please list_____

6. Women: Are you: Pregnant? Yes No Nursing? Yes No
   Taking birth control pills Yes No

In case of any emergency, contact_____Phone_____

Referred by_____

Dental Insurance

Employed by_____Occupation_____

Business address_____Business phone_____

Single_____Married_____Divorced_____Separated_____Widowed_____

Spouse Name_____

Spouse Employed By_____Occupation_____

Business Address_____Business phone_____

Person Responsible for Account (or Guardian)_____Relationship_____

Dental Insurance Company _____

Insured's Name _____Insured's SS# _____Insured's Date of Birth_____

Please sign below for the assignment of insurance benefits.

Signature_____Date_____

Financial Arrangements

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. We accept cash, checks, and credit cards. We will be happy to help you process your insurance claim form. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 1/2% per month

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. **Our treatment recommendations are based upon achieving optimum dental health and not based upon what your insurance company allows.**

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Signature_____Date_____