Central Virginia Dental Care, PLC
DBA
Drs. Rossetti, Myers, & Kondorossy

Patient Information

Name:______________________________ Birthdate:______________

Address:______________________ City:________________ State:______ Zip:__________

Cell phone:________________ Preferred phone:________________ Email:________________

Sex: ❑ M ❑ F Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employer or School:______________________________ Phone:________________

Social Security #:______________________________

Person to contact in case of an emergency:________________ Phone:________________

How did you learn about our practice or whom may we thank for referring you? ________________

____

Who is responsible for your account and payment? (If different from previous listing):________________

____

Address:______________________ City:________________ State:______ Zip: __________

Phone:________________ Email:________________ Birthdate: ______________

Dental Insurance

Insurance company:______________________________ Phone #: ________________

Subscriber's Social Security #:________________ Group #:______________ ID #: ______________

Address:______________________ City:________________ State:______ Zip:__________

Secondary Dental Insurance

Insurance company:______________________________ Phone #: ________________

Subscriber's Social Security #:________________ Group #:______________ ID #: ______________

Address:______________________ City:________________ State:______ Zip:__________

Dental History

Reason for today's visit:____

Date of last dental care visit:________________ Date of last dental x-rays: ________________

Former dentist's name:______________________________ Phone #: ________________

Check if you have any problem with the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between certain teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to any of the following: cold, hot, sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

How often do you floss?________________ How often do you brush?________________

Medical History

Your physician:______________________ Date of last visit:______________

Have you had any serious illnesses or operations? ❑ Yes ❑ No

If yes, describe:______________________

If yes, give approximate dates:______________________

Women are you pregnant? ❑ Yes ❑ No

Check if you have or have had any of the following:

- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis, rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joints, pins, ect.
- ❑ Asthma
- ❑ Bisphosphonates (osteoporosis drugs)
- ❑ Bleeding abnormally
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Congenital heart lesions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Heart problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ Herpes
- ❑ High blood pressure
- ❑ HIV AIDS
- ❑ Jaw pain
- ❑ Joint replacement
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Low bleed pressure
- ❑ Malignancies
- ❑ Mitral valve prolapse
- ❑ Pacemaker
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Sinus issues
- ❑ Stroke
- ❑ Thyroid problems
- ❑ Tobacco use
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer

List medications you are currently taking and the correlating diagnosis:

Medication	Diagnosis

Please list any allergies you may have:

Allergy	Allergy

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

______________________ ______________

Patient or Guardian Signature *Date*