BIGGERS
FAMILY DENTISTRY

13542 Waterford Place Midlothian, VA 23112 (804) 744-4000

Date_____

Patient's Name _____//_____

Last First Preferred Name

If Patient is a Minor - Parent/Guardian Name _____

Mailing Address _____

Home phone_____ Work phone _____Cell Phone_____

Birth date_____ **Social Security #** _____

Email Address_____

Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Employer_____ Occupation: _____

How did you hear about us ? _____

DENTAL INSURANCE INFORMATION

Policy Holder's Name_____ Date of Birth: _____ Policy ID#_____

Insurance Company_____

Phone No. _____ Do you have dual coverage? Yes_____ No_____

If yes: Policy Holder's Name_____ Date of Birth: _____

Policy ID #_____ Insurance Company_____

EMERGENCY INFORMATION

Emergency Contact: _____Phone Number: _____

MEDICAL HISTORY

Physician _____Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medication/anesthesia? _____

Yes No Any other allergies? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any operations?_____

Yes No Have you seen a physician in the last 12 Months? Why? _____

Yes No Do you snore? Or have you ever been told you gasp while sleeping? _____

Female Patients only:

Yes No Are you pregnant?_____

Circle any of the medical conditions below that you have had or currently have:

AIDS/HIV	Diabetes	High Blood Pressure	Sinus Problems
Anemia	Dizziness	Hepatitis/Jaundice	Stomach Problems
Arthritis	Drug Treatment	Herpes/Cold Sores	Stroke
Artificial Joints	Epilepsy/Seizures	Kidney Disease	**Organ Transplants/Implants**
Asthma/Hayfever	**Excessive Bleeding**	Liver Disease	Tuberculosis
Back Problems	Fainting	Low Blood Pressure	Tumors
Blood Disease	Glaucoma	Psychiatric Care	Thyroid Problems
Bone Disorders	Headaches	Nervous Disorders	Ulcers
Cancer	Head Injuries	Pacemaker	Venereal Disease
Chemotherapy/Radiation	Heart Disease	Respiratory Problems	Sleep Apnea
Circulatory Problems	Heart Murmur/MVP	Rheumatic Fever	
Cough	**Artificial Heart Valves**	Shortness of Breath	

*****Have you ever been treated for osteoporosis or osteopenia? If yes, what medication are, or have you EVER taken for treatment?_____

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

_____

DENTAL HISTORY

General Dentist _____Date of last visit_____

Have you ever had any complications following dental treatment?_____

What concerns you most about your teeth? _____

How would you rate your smile on a scale of 1-10 _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you ever lost or chipped any teeth?_____

Yes No Have there been any injuries to face, mouth, or teeth?_____

Yes No Is any part of your mouth sensitive to temperature? Where? _____

Yes No Is any part of your mouth sensitive to pressure? Where? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?_____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have "tension" headaches?_____

Yes No Have you ever or do you currently smoke or use tobacco products?_____

Yes No Have you ever experienced chronic ringing in your ears?_____

Signature: _____Date: _____