Deidra B. Kokel DDS, PC
17-C Fort Evans Road NE
Leesburg, VA 20176
703-777-5025

Patient Information

Name _____ **Preferred Name** _____ **Date** _____

SS# _____ **Gender** ◯ M ◯ F ◯ **Married** ◯ **Sing**le ◯ **Child**

Birthday _____ **Email Address** _____

Home#_____ **Cell#**_____ **Work#**_____

May we call you at work? ◯ **Yes** ◯ **No**

Address_____
Street **City** **State** **Zip**

HEALTH INFORMATION

Date of last Dental Visit: _____

Have you ever had any of the following? Please check all that apply.

- ☐ AIDS
- ☐ Dizziness
- ☐ Allergy Latex
- ☐ Epilepsy
- ☐ Allergy Other _____
- ☐ Fever Blister/Cold Sores
- ☐ Artificial Joints
- ☐ Growths
- ☐ Blood Transfusions
- ☐ Head Injuries
- ☐ Cancer
- ☐ Heart Disease
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ HIV Positive
- ☐ Respiratory Problems
- ☐ Severe Headaches
- ☐ Stroke
- ☐ Tumors
- ☐ Jaundice
- ☐ Mitral Valve Prolapse
- ☐ Oral Cancer/Tumor
- ☐ Pregnancy Due Date _____
- ☐ Diabetes
- ☐ Allergy Codeine
- ☐ Emphysema
- ☐ Allergy Rubber
- ☐ Fainting
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Blood Disease
- ☐ Head & Neck Radiation
- ☐ Bronchiti
- ☐ Heart Attack
- ☐ Chemotherapy
- ☐ Heart and Valve Defects
- ☐ Coronary Artery Disease
- ☐ Psychiatric Treatment
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Thyroid
- ☐ Ulcers
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Abnormal Bleeding
- ☐ Earaches/Ringing in Ears
- ☐ Allergy Metals
- ☐ Excessive Bleeding
- ☐ Anemia
- ☐ Gastritis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Breathing Difficulties
- ☐ Hearing Loss
- ☐ Chronic Cough
- ☐ Heart Murmur
- ☐ Colitis
- ☐ High Blood Pressure
- ☐ Radiation Treatment
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Urinate Frequently
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Prosthetic Heart

Have you been admitted into the hospital or needed emergency care in the past two (2) years? ◯ Yes ◯ No

If yes, please explain _____

Are you now under the care of a physician? ◯ Yes ◯ No

If yes, please explain _____

Name of Physician _____ Phone _____

Do you have any health problems that need further clarification? ◯ Yes ◯ No

Are you taking medication at this time? ◯ Yes ◯ No

Medication Name Dosage How Often How Long

_____

_____

_____

- Have you ever had Periodontal treatment? ◯ Yes ◯ No
- Are you dissatisfied with the appearance of your teeth? ◯ Yes ◯ No

  If yes, what would you like to change? _____
- Do you smoke? ◯ Yes ◯ No Do you chew tobacco? ◯ Yes ◯ No

  If yes, how much? _____ How long? _____
- Have you ever had an allergic reaction to medical anesthesia? ◯ Yes ◯ No

  If yes, what medicine? _____ What kind of reaction? _____
- Do you grind/clench your teeth during the day and night? ◯ Yes ◯ No
- Are you interested in teeth whitening? ◯ Yes ◯ No
- Have you ever had any trouble associated with dental treatment/surgery/extractions? ◯ Yes ◯ No

  If yes, please explain_____
- Have you ever had an unusual reaction to dental anesthetic? ◯ Yes ◯ No

  If yes, please explain_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health I will inform the dentist or staff at my next appointment

_____ _____

Signature of patient, parent, or guardian **Date**

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following info is for: ◯ the patient's spouse ◯ responsible party

Name _____ Gender ◯ M ◯ F ◯ **Married** ◯ **Sing**le ◯ **Other**

SS# _____ Birthday _____ Phone # _____

_____

Street City State Zip

EMPLOYMENT INFORMATION

Employer Name: _____ Occupation: _____

_____

Street City State Zip

PATIENT TREATMENT AND CONSENT

I authorize Dr. Deidra B. Kokel, her associates or designated staff treating me to perform such diagnostic aids deemed appropriate to make it a thorough diagnosis of my dental needs. These initial procedures include but are not limited to oral examination, x-rays, and intra oral pictures. Upon deciding such diagnosis, I authorize the dentist and her associates or designated staff to perform all recommended treatment and therapeutic procedures including administering medication as prescribed by the dentist and mutually agreed upon by me. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_Signature _____ Date _____