

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 ___ Single ___ 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.

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

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** ___ **Single** ___ **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 _____