



**Sebastian Bouroncle DDS**  
1900 Opitz Blvd, Ste C, Woodbridge, VA 22191  
450 Garisonville Rd, Ste 201, Stafford, VA 22554.  
www.virginianewsmiles.com

Welcome! Thank you for selecting our dental office. To help us meet all your health care needs, please complete this form as accurately as possible.

**1) PATIENT INFORMATION**

Patient full name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Other \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip C \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Previous Dentist: \_\_\_\_\_ Previous Dentist Phone: \_\_\_\_\_  
Current Physician: \_\_\_\_\_ Physician Phone #: \_\_\_\_\_  
Full Time Student: \_\_\_\_\_

**2) TELEPHONE & EMAIL**

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell # \_\_\_\_\_  
Email: \_\_\_\_\_  
In case of an emergency, who should we contact?  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_

**3) RESPONSIBLE PARTY**

Who is responsible for this patient? \_\_\_\_\_ Relationship: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip C \_\_\_\_\_  
Employer: \_\_\_\_\_ Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_

**4) INSURANCE INFORMATION**

**PRIMARY INSURANCE**

Name of Ins. Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Insured's SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Ins. Company name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Group # \_\_\_\_\_ ID # \_\_\_\_\_ Ins. Phone Number \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Ins. Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Insured's SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Ins. Company name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Group # \_\_\_\_\_ ID # \_\_\_\_\_ Ins. Phone Number \_\_\_\_\_

5) **MEDICAL HISTORY**

Do you consider yourself in good medical health?  Yes  No  
 Do you smoke or use tobacco in any forms  Yes  No  
 Do you have any metal rods, pins or Orthopedic Implants?  Yes  No  
 Do you require to PREMEDICATE for any MEDICAL CONDITIONS?  Yes  No  
 Are you taking any prescription/over the counter or herbal supplemental drugs?  Yes  No  
 Please list all medications currently taken: \_\_\_\_\_

Have you ever taken Fosamax, Actonel, Boniva, Didronel, Skelid or any medication for Osteoporosis?  Yes  No  
 Do you take any Blood thinners (Aspirin, Plavix, Coumadin...)?  Yes  No  
 Have you ever taken Phen- Phen?  Yes  No

**For Women:**

Are you Pregnant?  Yes  No / Nursing?  Yes  No \*\*\*\* If Pregnant, week # \_\_\_\_\_  
 Do you take Birth Control Rx.?  Yes  No

**Have you ever had any of the following medical problems?**

Abnormal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol/drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Bones/Joints/Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfussion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer/Chemo	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Deffect	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other :	_____
Herpes/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____

**Are you allergic to the following:**

Aspirin  Yes  No Erythromycin  Yes  No Tetracycline  Yes  No  
 Codeine  Yes  No Latex  Yes  No Penicillin  Yes  No  
 Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

6) **DENTAL HISTORY**

What is the reason for your visit today? \_\_\_\_\_ Are you currently in pain?  Yes  No  
 Have you ever had difficulties associated with any previous Dental work?  Yes  No  
 Have you ever had Gum treatment?  Yes  No  
 Have you ever had pain in your jaw joint (TMJ/TMD)?  Yes  No  
 Do your gums bleed?  Yes  No  
 Are your teeth sensitive to hot, cold or both?  Yes  No  
 When was the last time you had a cleaning? \_\_\_\_\_ How many times a week do you floss? \_\_\_\_\_

I understand that the information I have given today is correct to the best of my knowledge, I also understand that this information will be held in confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need.

\_\_\_\_\_  
 Patient/ Guardian Signature

\_\_\_\_\_  
 Date