NORTHERN VIRGINIA DENTAL SOLUTIONS
8292 OLD COURTHOUSE RD
UNIT B
VIENNA, VA 22182
Ph # : 703-893-1603
Fax # : 703-893-0200

Northern Virginia Dental Solutions
Dr. Julia Lokitis, DDS, PLLC

Patient Personal Information

Title		Preferred Name		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				Emergency Contact	Emergency Phone #
Email				Student	SSN
Health Care Guardian Name				School Name	
Health Care Guardian Phone #				Referral Type	

Person responsible/guarantor for paying bills

Title		Preferred Name		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance? __ Yes __ No				**Do you have Secondary Dental Insurance?** __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergic To

- ☐ Y ☐ N No Known Allergies
- ☐ Y ☐ N LATEX Rubber
- ☐ Y ☐ N Penicillin or Amoxicillin!
- ☐ Y ☐ N Clindamycin
- ☐ Y ☐ N Aspirin/Ibuprofen
- ☐ Y ☐ N Epinephrine
- ☐ Y ☐ N Narcotics
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N Fruit, what kind?
- ☐ Y ☐ N Other Antibiotics or Drugs:

Check, if applicable

- ☐ Y ☐ N Abnormal Bleeding
- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Angina/ Chest Pain
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Contact Lenses
- ☐ Y ☐ N Congestive Heart Failure
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Diabetes TYPE 1
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Herpes, Oral
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems

Other

- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Prolia, Fosamax, Reclast
- ☐ Y ☐ N IV or Oral Bisphosphonates
- ☐ Y ☐ N Radiation to Head or Neck
- ☐ Y ☐ N Anything Else?

Additional Comments

Dental Questionnaire

Dental Questionnaire

Date of your last cleaning

Date of your last x-rays

Do your gums bleed while brushing or flossing ?

Are your teeth sensitive to cold or sweets ?

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ?

Have you had any head, neck or jaw injuries ?

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ?

Do you clench or grind your teeth ?

Have you ever had orthodontic treatment ?

If Yes, as adult or child?

Do you wear dentures or partials ?

Are you happy with your dentures ?

Are you having any specific problems or pain with your teeth, gums, or mouth at this time ?

Please explain

Are you happy with your smile ?

Do you have an unpleasant taste or odor in your teeth/mouth ?

Does food catch between your teeth ?

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list

Medical Questionnaire

Emergency Contact

Emergency contact name

Emergency contact phone

Emergency contact relationship to patient

Medical Questionnaire

Family Physician

Phone

Are you currently under care of a Physician ?

Have you had any serious illness, operation or been hospitalized within the past 5 years ?

If Yes, what illness or problem ?

Do you smoke ?

Do you use smokeless tobacco like dip or SNUS or ZYN	
Are you currently taking any medication ?	
If Yes, what ?	
Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)	
Women Only	
Are you pregnant?	
If Yes, what is your due date ?	
Are you currently nursing ?	
Are you on birth control pills / fertility drugs ?	
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**

Dentist Signature **Date**