Claudio Iwamoto DDS MS • 19490 Sandridge Way Suite 270 • Lansdowne, VA 20176 • (703)858-3838

Patient Information

Patient Name: _____ Date: _____
LAST FIRST MI (PREFERRRED)

Gender: □ Female □ Male □ Married □ Single □ Child □ Other

Social Security #: _____ Birth Date: _____

Address: _____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

Phone (Home): _____ (Work): _____ (Cell): _____

Email: _____ Pharmacy/Location: _____

Employer Name: _____ Occupation: _____

Address: _____ Phone: _____
STREET CITY STATE ZIP

Health Information

Date of last dental visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

□Allergies: _____
_____
_____
_____

□ AIDS/HIV
□ Anemia
□ Angina
□ Arthritis
□ Artificial Joints
□ Asthma
□ Blood Disease
□ Cancer
□ Diabetes
□ Dizziness/Fainting
□ Epilepsy/Seizures
□ Excessive Bleeding
□ Glaucoma
□ Growths or Tumors
□ Hay Fever
□ Head Injuries
□ Heart Attack
□ Heart Disease
□ Heart Murmur
□ Hepatitis
□ High Blood Pressure
□ Kidney Disease
□ Liver Disease/Jaundice
□ Mental Disorders
□ Nervous Disorders
□ Pacemaker
□ Phen-Fen Usage
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Sexually Transmitted Disease
□ Sinus Problems
□ Smoking/Tobacco Use
□ Steroids
□ Stomach Problems
□ Stroke
□ Tuberculosis
□ Thyroid Problems
□ High Cholesterol
□ Current Medications:
_____
_____
_____
□ OTHER:
_____

□ Yes, □ No: Have you been admitted to a hospital or needed emergency care during the past two years?

□ Yes, □ No: Are you now under the care of a physician?
Name of Physician: _____ Phone #: _____

□ Yes, □ No: Are you pregnant or is there a possibility you may be pregnant?

□ Yes, □ No: Do you have any concerns that you would like to discuss with the doctor privately?

□ Yes, □ No: Have you ever had any complications following dental treatment?

□ Yes, □ No: Do you grind your teeth?

□ Yes, □ No: Do your jaw joints ever click, pop, or give you pain?

□ Yes, □ No: Have you ever had periodontal treatment in the past?

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 doctor at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice?
□Dental Office: _____ □Other: _____

FOR OFFICE USE ONLY

Prescriptions Needed: _____