KATHERINE MCGRATH, DDS, PC
9679-A MAIN STREET
FAIRFAX, VA. 22031
PHONE 703-978-6556
FAX 703-426-1405

We would like to take this opportunity to thank you for choosing our practice for your dental care!!!

Patient Information

Today's Date _____

Name_____ Preferred Name _____

Address_____ City_____ State_____ Zip _____

Email_____ Home Phone_____ Work Phone_____ Cell Phone _____

Contact in Case of an Emergency _____ Phone_____

Whom may we thank for referring you? _____

Social Security Number_____ Date of Birth _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Driver's License # _____ State _____

Patient's Employer_____ Phone_____

Address_____ City_____ State_____ Zip _____

Name of Responsible Party _____

Relationship to Patient_____ Date of Birth _____

Address_____ City_____ State_____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone _____

Employer_____ Phone_____

Address _____

Insurance Information

Name of Insured _____

Relationship to Patient_____ Birthdate_____ SS# _____

Employer_____ Phone_____

Address_____ City_____ State_____ Zip _____

Insurance Company_____ Group #_____ Policy # _____

Ins. Co. Address_____ City_____ State_____ Zip _____

Secondary Insurance Information

Name of Insured _____

Relationship to Patient_____ Birthdate_____ SS# _____

Employer_____ Phone_____

Address_____ City_____ State_____ Zip _____

Insurance Company_____ Group #_____ Policy # _____

Ins. Co. Address_____ City_____ State_____ Zip _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken bisphosphonates (Fosamax, Boniva)?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Do you have or have you had any of the following?		

	Yes	No
9. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
11. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Respiratory Problems	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Mitral Valve Prolapse	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other _____	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	_____		

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

I certify that I have read and understand the above information to the best of my knowledge. The questions pertaining to my personal, insurance and health information have been accurately answered.

X _____

Signature of patient (or parent/guardian if minor)