CEDAR CREEK DENTAL
Dr. Alexis Mierzwa
650 Cedar Creek Grade, Suite 211 Winchester VA 22601
PH# 540-486-5111 FAX 888-699-6657

Patient name: _____ Sex: _____

SS #:_____ Date of birth: _____

Physical address: _____

City: _____ State: _____ Zip: _____

Billing address (if different): _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____

Referred by: _____

Employer/Occupation: _____ Bus. Phone: _____

Emergency phone # and relationship to contact: _____

Primary dental insurance: _____

Address _____

ID #: _____ Group #:_____

Subscriber's name: _____ Date of birth: _____

How did you come to choose our office for your dental care?_____

Problems of the jaw:	Yes	No	***Are your teeth sensitive to?***	Yes	No
Clicking of the jaw	☐	☐	Heat	☐	☐
Pain (joints, ears, side of face)	☐	☐	Cold	☐	☐
Difficulty opening or closing	☐	☐	Sweets	☐	☐
Difficulty chewing	☐	☐	Biting Pressure	☐	☐

General Information:

When was your last dental appointment? _____

Are you dissatisfied with your teeth & their appearance? _____

If yes what would you change? _____

Yes No

Have you ever been diagnosed with sleep apnea? ☐ ☐

Are you currently using any sleep appliance? ☐ ☐

	Yes	No
Do you sleep well at night?	☐	☐
Do you snore?	☐	☐
Does food catch between your teeth?	☐	☐
Do your gums bleed when brushing?	☐	☐
Have you noticed any gum swelling around your teeth?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Do you ever avoid any part of your mouth while brushing?	☐	☐
Have you ever had a reaction to local anesthetic?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Are you deeply concerned about finances required to return your teeth to excellent dental health?	☐	☐
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	☐	☐
Have you ever had any teeth removed?	☐	☐
If so how long have they been missing? _____		
Do you feel you will eventually wear artificial dentures?	☐	☐
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
If so, drinks per week? _____		

To The Best of Your Knowledge, Are You Or Have You Ever Been Afflicted with:

We must disclose that Virginia has a Prescription Monitoring Program (PMP). In Virginia we may be required to use the Prescription Monitoring Program (PMP) prior to prescribing.

	Yes	No		Yes	No
Heart Ailment _____	☐	☐	ealing Complications	☐	☐
Diabetes	☐	☐	Allergy to any drug? _____		
Rheumatic Fever	☐	☐	_____		
Epilepsy	☐	☐	e you pregnant	☐	☐
High Blood Pressure	☐	☐	Are you nursing	☐	☐
Respiratory Problems	☐	☐	Trying to conceive	☐	☐
Hepatitis	☐	☐	Medication List: _____		

HIV Positive ☐ ☐ _____

Prolonged Bleeding ☐ ☐ _____

May we use your photos/radiographs for educational or marketing purposes?" Yes or No

Signature:_____ Date: _____