Maribel M. Vann, DDS
PREVENTION · PROTECTION · RENEWAL

8500 Executive Park Ave, Suite 408, Fairfax, VA 22031
Telephone: (703) 204-1555 Fax: (703) 204-1610

WELCOME TO OUR PRACTICE

We appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us and we will be more than happy to help.

ABOUT YOU

Today's Date: Sex: ◯ M ◯ F

Full Name:

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: Age: SSN:

Home Address: City: State: Zip:

Home Phone: Work Phone: Cell:

Employer: Employer's Address:

Occupation:

Whom do we thank for referring you?

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN YOURSELF)

Name: Relationship:

Billing Address:

Home Phone: Work Phone: SSN:

Employer: How long there? Occupation?

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SPOUSE INFORMATION

His/Her Name:

Birth Date: SSN:

Employer: Work Phone: Ext:

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: Phone: Group/Policy#:

Insurance Co. Address:

Insured's Name: Insured's SSN:

Insured's Birth Date: Relation:

Insured's Employer: Employer's Address:

Secondary Insurance

Insurance Co. Name: Phone: Group/Policy#:

Insurance Co. Address:

Insured's Name: Insured's SSN:

Insured's Birth Date: Relation:

Insured's Employer: Employer's Address:

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MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: _____

Do you have or ever had any of the following? PLEASE check those that apply:

- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Angina
- ☐ **Artificial Joints**
- ☐ **Artificial Heart Valves***
- ☐ Asthma
- ☐ Arthritis
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizziness
- ☐ Fever/Blister/Cold Sores
- ☐ Glaucoma
- ☐ **Heart Disorder (Congenital)***
- ☐ **Heart Infection***
- ☐ **Heart Pace Maker***
- ☐ **Heart Murmur***
- ☐ **Heart Surgery***
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ **HIV*/AIDS**
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Mental Disorder
- ☐ **Mitral Valve Prolapse***
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ **Stents (Location)**
- ☐ **Surgical Shunt***
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

*** This Condition may require antibiotic Premedication for certain dental procedures.**

Do you have any health problems that were not listed above or need further clarification? ◯ Yes ◯ No

If Yes, please explain: _____

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Are you now under the care of a physician? ◯ Yes ◯ No

If Yes, please explain:

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

If Yes, please explain:

Are you taking any medications? ◯ Yes ◯ No

If Yes, please explain:

Are you allergic to any medications or substances? ◯ Yes ◯ No

If Yes, please explain:

Are you using or have you used Tobacco? ◯ Yes ◯ No

If Yes, please explain:

Are you currently pregnant? ◯ Yes ◯ No

To the best of my knowledge, all of the preceding answers are correct. If you have any changes in your health status or if your medications change, I will inform the dentist and the staff at the next appointment without fail.

Date:

Signature of patient, parent or guardian: _____

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DENTAL HEALTH QUESTIONNAIRE

The cornerstone of our practice is the examination process. Our first task is to help you identify what it is that you want, both in the short term and in particular, for the long term. We feel everyone deserves to know the state of their dental health, what is moving them away from health, and the choices available to restore their oral health. If your first appointment is for a cleaning or an emergency visit, your exam will likely be cursory with limited x-ray. If you are here for a comprehensive exam, we will examine your soft tissues, teeth, gums, and chewing system. Depending on the clinical findings, we will take appropriate x-rays, impressions for models of your teeth, and photographs.

Excellence in dentistry begins with careful diagnosis and treatment plan. Once all of your diagnostic records have been completed and evaluated, we will visit with you and review the findings, discuss your options, and together, create a personalized plan. It is important to note that once we have agreed on your plan, that quality is the constant and time is the variable. **You always control how far and at what pace we will proceed.**

Please help us better understand your dental health needs and goals by answering the following questions below (check the best answer):

1. I have a fear of going to the dentist? ◯ Yes ◯ No
2. My mouth and teeth are comfortable? ◯ Yes ◯ No
3. I am satisfied with the appearance/condition of my teeth? ◯ Yes ◯ No
4. I think my present state of dental health is? ◯ Good ◯ Fair ◯ Bad
5. I would say my main concerns with my dental health are? _____
6. I'm interested in a smile evaluation and personalized treatment plan to enhance by smile. ◯ Yes ◯ No
7. Have you had a FULL MOUTH set of X-rays (other than routine cavity detecting X-ray) within the last 3 years?

   ◯ Yes ◯ No

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APPOINTMENTS

Because we recognize the value of your time, you can expect us to see you at the appointed time, so as to keep your time spent in our office as short as possible. Likewise, when you make an appointment with us we have reserved our time just for you and ask that you be on time. **If you cannot keep your appointment we ask you to give us at least 48 hours notice so that we can give your time slot to another patient. Otherwise, our office policy is to charge an hourly rate to help defer some of the overhead expense associated with the loss of time.** We believe very strongly that mutual trust and respect for each other's time will strengthen our relationship.

FINANCIAL POLICY

Unless another financial option is pre-arranged, payment in full is due the day of treatment.

Payment Options

1. For your convenience we accept Cash, Check, Visa, MasterCard, and Discover.
2. Feel free to discuss your financial concerns with any of our staff. We are committed to helping you remove all barriers on your journey to health.

   For patients with Dental Insurance:
   As a courtesy, we will assist you in getting your benefit from your insurance company.

AUTHORIZATION AND CONSENT

GENERAL CONSENT TO TREATMENT:
I agree and consent to a dental examination by Dr. Vann. I understand that additional diagnostic procedures and treatments may be recommended and will be discussed with me before being done. I acknowledge that there are no guarantees, express or implied, as to the results of any procedures or dental treatment.

Release of Information
I authorize Dr. Vann to release any information regarding my dental/medical history diagnosis or treatment to third party payors and/or other health professionals.

Photography Release
I authorize Dr. Vann to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize her to show these photographs in an educational setting as well as to other patients to better explain their treatment options (as you may be shown photographs for the same reason).

My Signature acknowledges that:
I understand the office policy with keeping appointments.
I understand and comply with the Office Financial Policy.
I understand and agree to the General Consent to Treatment.
I authorize the Release of Information.
Photographs taken of me may be used in a teaching environment.
I have received a copy of the office Notice of Privacy Practices.

Date: _____ Signature of patient, parent or guardian: _____