HARVEY M LEVIN
DDS PLLC
WE ALWAYS GIVE 100%

1712 EYE STREET, NW, STE 802
WASHINGTON, DC, 20006-3748
PHONE 202.466.4466
EMAIL: TOOTHDOC@STARPOWER.NET

Patient Information

Date_____

Name: _____
Address: _____
_____
Home Phone: _____
Cell Phone: _____
Email: _____
Date of Birth: _____ **Age:**_____
S.S.# _____
Marital Status: □ S □ M □ D □ W
Employer: _____
Address: _____
_____
_____
Office Phone:_____
Office Fax: _____
Occupation: _____

Spouse: _____
Spouse's Office Phone: _____
In An Emergency, Call: _____
Phone: _____

Previous Dentist: _____

Person Responsible
For This Account: □ Self
□ Other _____
Responsible Person's Phone:_____

Are You A Member Of
A Dental Benefit Plan? _____
Referred By: _____
(We Like To Say Thanks)

REASON FOR VISITING OUR OFFICE

□ **Full Mouth Evaluation**
□ **Cleaning and Check-up**
□ **Aesthetic Consultation**
□ **Restorative Consultation**
□ **Problem Tooth**
□ **Problem Area**
□ **Implant Consultation**
□ **Other** _____

***Has there been a change in your health in the last year?**	**Yes**	**No**
_____		
_____		
***Are you NOW under the care of a physician?**	**Yes**	**No**
Dr._____		
Phone_____		
***Have you had any serious illnesses or operations or have been hospitalized in the last 5 years?**	**Yes**	**No**
_____		
_____		
***Do you smoke?**	**Yes**	**No**
***Are you presently taking any medication?**	**Yes**	**No**
_____		
_____		
***Are you allergic to any metal or jewelry?**	**Yes**	**No**
***WOMEN Are you pregnant?**	**Yes**	**No**
Are you nursing?	**Yes**	**No**
Menstrual problems?	**Yes**	**No**
Are you taking birth control pills?	**Yes**	**No**
***Are you taking any blood thinners?**	**Yes**	**No**
_____		
_____		

(OVER)

*** Have you ever taken or do you now take any diet pills ?** **Yes** **No**

***Can you take IBUPROFEN (ADVIL, MOTRIN, NUPRIN) ?** **Yes** **No**

*** Do you have any history of the following conditions?**

Cardiovascular Disease			**Yes**	**No**
Congenital Heart Disease			**Yes**	**No**
Damaged or Artificial Heart Valves			**Yes**	**No**
Prosthetic Joints			**Yes**	**No**
Heart Murmur			**Yes**	**No**
Mitral Valve Prolapse			**Yes**	**No**
High Blood Pressure O	**Low Blood Pressure O**		**Yes**	**No**
Blood Disorders			**Yes**	**No**
Excessive Bleeding			**Yes**	**No**
Hay Fever			**Yes**	**No**
Sinus Problems			**Yes**	**No**
Asthma			**Yes**	**No**
Arthritis			**Yes**	**No**
Inflammatory Disease			**Yes**	**No**
Thyroid Disease			**Yes**	**No**
Diabetes			**Yes**	**No**
Epilepsy			**Yes**	**No**
Seizures			**Yes**	**No**
Kidney Disease			**Yes**	**No**
Hepatitis			**Yes**	**No**
Tuberculosis			**Yes**	**No**
Venereal Disease			**Yes**	**No**
HIV			**Yes**	**No**
AIDS			**Yes**	**No**
Cancer----------O	**Abnormal Growths**	**O----------**	**Yes**	**No**
Depression--------O	**Mental Health Disorders**	**O----------**	**Yes**	**No**
Within The Last Year Have You Had?				
Chemotherapy--O and/or	**Radiation Treatment**	**O----------**	**Yes**	**No**

*** Are you allergic to or do you react badly to?**

Penicillin		**Yes**	**No**
Sulfa Drugs		**Yes**	**No**
Other Antibiotics		**Yes**	**No**
Codeine		**Yes**	**No**
Narcotics		**Yes**	**No**
Alcohol		**Yes**	**No**
Local Anesthetic		**Yes**	**No**
Aspirin		**Yes**	**No**
Latex		**Yes**	**No**
Anything Else		**Yes**	**No**

*** Is there anything else that we should know about your health or medical history?**

_____

_____

_____

*** I authorize the release of medical information necessary to process claims for dental benefits.**
*** I understand that there will be a fee charged equal to the fee of the appointed procedure, not to exceed $250.00, for missed office visits if 24 hours notice is not given. If a weekend or holiday precedes your appointment, a full business day's notice must be given to avoid this charge.**
*** Thank you for allowing us to be your dental health care providers.**
*** We take pride in two things: The quality of our dental care and how we treat our patients.**
*** We always give 100% !**

_____ _____

Patient's signature or Parent/ Guardian's signature (if minor patient) **Date**