Fredericksburg Dental Artists

New Patient Registration Form

Yosreldin Koheil DDS FIOCI FAGD
10040 Jefferson Davis Highway Suite 112
Fredericksburg, Va 22407

Date _____

Patient Information

Last Name_____ First Name_____ Middle Int_____
Date of Birth_____ Sex M / F Social Security #_____
Employer_____ Occupation_____

What is the best method for contact? Please provide two ways for us to reach you:

Home Phone_____ Work Phone_____ Cell Phone_____
Do you prefer text message? Y / N Email_____

Address_____ Apt/Unit_____
City_____ State_____ Zip_____

Emergency Contact _____Relationship_____
Phone Number_____

How did you hear about us? _____

Who can we thank for referring you? _____

Would you like for us to bill your insurance on your behalf?

Primary Insurance _____ Subscriber_____
Address_____ Subscriber Date of Birth_____
City_____ State_____ Zip_____ Payer ID #_____
Phone Number_____ ID#_____ Group #_____

Secondary Insurance _____ Subscriber_____
Address_____ Subscriber Date of Birth_____
City_____ State_____ Zip_____ Payer ID #_____
Phone Number_____ ID#_____ Group #_____

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Medical and Dental Questionnaire

Patient Name _____

Email _____

Date of Birth ____/____/_____

Mark your response to indicate if you have had any of the following diseases or problems.
Mark don't know (DK) if you are unsure whether you have had the disease or problem.
If you have a disease or problem that is not listed below, write the disease or condition in the space at the bottom of this form.

Physician's Name _____ Physician's Phone Number: _____

Physician's Address _____

Date of last physical examination: _____

Yes	No	DK	
☐	☐	☐	Any changes in your health within the past year?

Yes	No	DK	Cardiovascular
☐	☐	☐	High blood pressure
☐	☐	☐	Angina (chest pain)
☐	☐	☐	Heart attack
☐	☐	☐	Irregular heart beat
☐	☐	☐	Heart surgery
☐	☐	☐	Heart failure
☐	☐	☐	Damaged heart valve
☐	☐	☐	High cholesterol
☐	☐	☐	Heart infection
☐	☐	☐	Stroke

Yes	No	DK	Hematologic
☐	☐	☐	Anemia
☐	☐	☐	Sickle cell anemia
☐	☐	☐	Abnormal bleeding

Yes	No	DK	Respiratory
☐	☐	☐	Asthma
☐	☐	☐	Emphysema/bronchitis
☐	☐	☐	Sleep apnea
☐	☐	☐	Difficulty breathing

Yes	No	DK	Endocrine
☐	☐	☐	Diabetes
☐	☐	☐	Thyroid problem

Yes	No	DK	Renal
☐	☐	☐	Kidney disorder
☐	☐	☐	Dialysis

Yes	No	DK	Immune
☐	☐	☐	Past use of steroids
☐	☐	☐	Delayed healing

Yes	No	DK	Musculoskeletal
☐	☐	☐	Arthritis
☐	☐	☐	Artificial joint
☐	☐	☐	Fibromyalgia
☐	☐	☐	Lupus
☐	☐	☐	Sjogren's Syndrome
☐	☐	☐	Osteoporosis

Yes	No	DK	Gastrointestinal
☐	☐	☐	Acid reflux/GERD
☐	☐	☐	Irritable bowel syndrome
☐	☐	☐	Stomach ulcer

Yes	No	DK	Hepatic
☐	☐	☐	Liver disease
☐	☐	☐	Jaundice
☐	☐	☐	Hepatitis A B C

Yes	No	DK	Neurologic
☐	☐	☐	Epilepsy/seizures
☐	☐	☐	Parkinson's Disease
☐	☐	☐	Multiple sclerosis
☐	☐	☐	Headaches

Yes	No	DK	Skin
☐	☐	☐	Hives or skin rash
☐	☐	☐	Other skin lesions

Yes	No	DK	Eyes/Ears
☐	☐	☐	Glaucoma
☐	☐	☐	Impaired vision
☐	☐	☐	Impaired hearing

Yes	No	DK	Mental Health
☐	☐	☐	Bipolar disorder
☐	☐	☐	Depression
☐	☐	☐	Anxiety
☐	☐	☐	Eating disorders
☐	☐	☐	Sleep disorder
☐	☐	☐	Dementia
☐	☐	☐	Learning disorders

Yes	No	DK	Infections
☐	☐	☐	HIV positive/AIDS
☐	☐	☐	Sexually transmitted disease

Yes	No	DK	Allergies
☐	☐	☐	Local anesthetic
☐	☐	☐	Antibiotics
☐	☐	☐	Aspirin/ibuprofen
☐	☐	☐	Acetaminophen (Tylenol)
☐	☐	☐	Codeine/narcotics
☐	☐	☐	Metals
☐	☐	☐	Latex
☐	☐	☐	Other:_____

Yes	No	DK	Other
☐	☐	☐	Cancer
☐	☐	☐	Cancer treatment
☐	☐	☐	Nursing infant
☐	☐	☐	Tobacco use
☐	☐	☐	Alcohol use
☐	☐	☐	Chemical dependency
☐	☐	☐	Street/recreational/ illicit drug use

Please list any disease, condition, or hospitalizations and surgeries that are not listed above.

_____

Please list any BLOOD THINNERS you are taking.

_____

Women Only

Are you pregnant? Y☐ N☐ DK☐ Taking birth Control Pills Y☐ N☐ Breast feeding Y☐ N☐

Patient Name: ____________________

Date of Birth __/__/__________

Medication List

For use by dentist

Patient to fill out

Medication & Dose	Condition prescribed for	MM/YYYY started	Update section (enter date of change & the new dose of medication. If discontinued, enter D/C)		
			Date/Change	Date/Change	Date/Change

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HIPAA Acknowledgement

Yosreldin Koheil DDS FIOCI FAGD
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Patient Name: DOB:

Acknowledgement of receipt of notice of privacy practices, consent/limited authorization & release form. You may refuse to sign this.

I, , have received a copy of this office's Notice of Privacy Practices.
(Please print name)

Signature: Date:

Please list any party who can have access to your health information:

Name:.....Relationship:.....

Name:.....Relationship:.....

Name: .....Relationship:.....

Please complete how you would like us to contact you from the following:

Please address me by:

First Name Only

Proper Sir Name

Other