Kieu M. Le, D.D.S.,PLLC
Family and Cosmetic Dentistry
12359 Sunrise Valley Drive
Suite 100
Reston, VA 20191

Patient Information

Patient Name: ______________________________ Date: __________
Last, First MI (Preferred Name)
Gender: ______ Family Status: ________ **Email: ____________________
Social Security #: ____________________ Birth Date: ____________________
Phone (Home): ________ (Work): ____________ * (**Cell**)____________

Address: ____
Street Apartment #
____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice?

Health Information

Date of Last Dental Visit:____________Reason for this visit: ____________________

Have you ever had any of the following? Please check those that apply:

- ☐ **AIDS**
- ☐ **Allergies** __________ __________
- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Artificial Joints**
- ☐ **Asthma**
- ☐ **Blood Disease**
- ☐ **Cancer**
- ☐ **Diabetes**
- ☐ **Dizziness**
- ☐ **Epilepsy**
- ☐ **Excessive Bleeding**
- ☐ **Fainting**
- ☐ **Glaucoma**
- ☐ **Growths**
- ☐ **Hay Fever**
- ☐ **Head Injuries**
- ☐ **Heart Disease**
- ☐ **Heart Murmur**
- ☐ **Hepatitis**
- ☐ **High Blood Pressure**
- ☐ **Jaundice**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Mental Disorders**
  - ☐ **Nervous Disorders**
  - ☐ **Dementia**
  - ☐ **Alzheimers**
- ☐ **Pacemaker**
- ☐ **Pregnancy** **Due date:**________
- ☐ **Radiation Treatment**
- ☐ **Respiratory Problems**
- ☐ **Rheumatic Fever**
- ☐ **Rheumatism**
- ☐ **Sinus Problems**
- ☐ **Stomach Problems**
- ☐ **Stroke**
- ☐ **Tuberculosis**
- ☐ **Tumors**
- ☐ **Ulcers**
- ☐ **Venereal Disease**
- ☐ **Codeine Allergy**
- ☐ **Penicillin Allergy**

OTHER:
- ☐ **Snoring**
- ☐ **Sleep Apnea**
- ☐ **Vertigo**
- ☐ **Migraines**

- Are you now under the care of a physician for any illness or other problems other than routine care?
  ☐ Yes ☐ No
- If yes Name of Physician: ____________________Phone: ____________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Have you ever taken any of the group of drugs collectively for Osteoporsis treatment such as (Boniva,Prolia or Reclast)? Please circle Yes or No

*****Please give us any Dental Insurance changes to update *****

•**List any medications you are currently taking and the correlating diagnosis**

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To the best of my knowledge all of the preceding answers and information provided are the true and correct. If I ever have any changes in my health, I will inform the doctor at each appointment without fail.

Health History Change ______________________ **Signature and Date**

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Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________ Birth Date: ______________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best time to call: ______________

Address: ____
Street Apartment #

____
City State Zip Cod