Welcome

DR. CHARLES D. DIETRICH
DR. CATHERINE D. PULSE
5028 WISCONSIN AVENUE, N.W.
SUITE 102
WASHINGTON, DC 20016
(202) 363-6177

Patient Information (CONFIDENTIAL)

SS# ____________
Date ____________

Name ____________ Birthdate ____________ Home Phone ____________
Address ____________ City ____________ State ______ Zip ______
Email ____________ Cell Phone ____________
Check Appropriate Box: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated
Patient Employer ____________
Patient Occupation ____________ Work Phone ____________
Business Address ____________ City ____________ State ______ Zip ______
Whom May We Thank for Referring You? ____________
Person to Contact in Case of Emergency ____________ Phone ____________

Responsible Party

Name of Person Responsible for this Account ____________ Relationship to Patient ____________
Address ____________ Home Phone ____________
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured ____________ Relationship to Patient ____________
Birthdate ____________ SS# ____________ Date Employed ____________
Name of Employer ____________ Union or Local# ____________ Work Phone ____________
Address of Employer ____________ City ____________ State ______ Zip ______
Insurance Company ____________ Group# ____________ Policy/ID# ____________
Ins. Co. Address ____________ City ____________ State ______ Zip ______

Patient Dental History

Name of Previous Dentist and Location ____________ Date of Last Exam ____________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐

	Yes	No
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐
17. Have you ever worn a biteguard?	☐	☐
If yes, date of placement ____________		

Over Please

Patient Medical History

Physician ______________ Office Phone ______________ Date of Last Exam ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any	☐	☐
surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________		
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐

7. Are you allergic to or have you had any reaction to the following?	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________		
8. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 wks.)	☐	☐
9. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

6. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other ______________	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ______________________________

Signature of patient (or parent/guardian if minor)

Doctor's Comments ______________________________

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______________ Signature ______________ Date ______________