Kieu M. Le, D.D.S.
Sunset Hills Professional Center
11351 Sunset Hills Road
Reston, Va. 20190
703-709-0330

Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____

Address: _____
Street Apartment #

_____
City State Zip Code

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	☐ Epilepsy/ Head Injury	☐ Pregnancy	☐ Allergies _____
☐ Anemia	☐ Fainting	Due date:_____	_____
☐ Arthritis	☐ Glaucoma	☐ Radiation Treatment	_____
☐ Artificial Joints	☐ Hay Fever	☐ Respiratory Problems	_____
☐ Asthma	☐ Heart Disease	☐ Rheumatic Fever	
☐ Blood Disease	☐ Heart Murmur	☐ Stomach Problems	
☐ Chemotherapy	☐ Hepatitis/Jaundice	☐ Stroke	
☐ Chest Pain	☐ High Blood Pressure	☐ Thyroid Treatment	
☐ Coumadin Therapy	☐ Kidney Disease	☐ Tuberculosis	
☐ Diabetes	☐ Liver Disease	☐ Venereal Disease	
☐ Dizziness	☐ Migraines	OTHER	
☐ Drug/Alcohol Dependency	☐ Nervous Disorders	☐ _____	
	☐ Pacemaker		

- Have you ever had any complications following dental treatment? ☐ 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 now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- Please list medications you are currently taking_____

_____

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

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____