WELCOME

ABOUT YOU

Today's Date:___/___/___ Email:_____
Name:_____
I prefer to be called:_____ ☐M ☐F
Birthdate:____/____/____ Age:___ SS#:_____-____-_____
Home Address:_____
_____
☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Hm#:(_____)_____-_____ Cell #:(_____)_____-_____
Wk#:(_____)_____-_____ Ext:_____ DL#:_____
Employer:_____
Address:_____
How long there?_____ Occupation:_____
When are the best times to reach you?_____
How did you hear about our office?
_____
Other family members seen by us:_____

EMERGENCY CONTACT (Not living with you)

Name:_____
Wk#:(_____)_____-_____ Hm#:(_____)_____-_____
Address:_____
_____
Relation:_____
May we contact him/her to set up dental care? ☐Y ☐N
Contact #: _____

MEDICAL HISTORY

Have you ever had any of the following medical problems?

Y N Abnormal Bleeding _____
Y N Acid Reflux_____
Y N Alcohol/Drug Abuse_____
Y N Anemia_____
Y N Anxiety_____
Y N Arthritis_____
Y N Artificial Bones/Joints/Valves _____
Y N Asthma_____
Y N Blood Transfusion_____
Y N Cancer/Chemotherapy_____
Y N Colitis_____
Y N Congenital Heart Defect_____
Y N Depression _____
Y N Diabetes_____
Y N Difficulty Breathing_____
Y N Emphysema_____
Y N Epilepsy_____
Y N Fainting Spells_____
Y N Fever Blisters_____
Y N Frequent Headaches_____
Y N Glaucoma _____
Y N Hay Fever_____
Y N Heart Attack_____
Y N Heart Murmur_____
Y N Heart Surgery_____
Y N Hemophilia_____

Explain any of the above:_____
_____

FAMILY INFORMATION

Spouse's Name:_____
Employer:_____
Wk#:(_____)_____-_____ Ext:_____ DL#:_____
Birthdate:____/____/____ Age:___ SS#:_____-____-_____
Children's Names Birthdate
_____ ____/____/____
_____ ____/____/____

Person Responsible for Account:_____
Wk#:(_____)_____-_____ Hm#:(_____)_____-_____
Billing Address:_____
_____
Relationship:_____ SS#:_____-_____-_____
Employer:_____ DL#:_____

INSURANCE

Primary Insurance
Dental Coverage? ☐ Yes ☐ No
Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone#:(_____)_____-_____
Group # (Plan, Local, or Policy #):_____
Insured's Name:_____ Relation:_____
Insured's Birthdate:____/____/____ SS#:____-____-_____
Insured's Employer:_____
Employer's Address:_____
Do you have secondary insurance? ☐ Yes ☐ No

Y N Hepatitis (A/B/C)_____
Y N Herpes_____
Y N High Blood Pressure_____
Y N High Cholesterol_____
Y N HIV/AIDS _____
Y N Hospitalized_____
Y N Kidney Problems_____
Y N Liver Disease_____
Y N Low Blood Pressure _____
Y N Mitral Valve Prolapse _____
Y N Pacemaker _____
Y N Radiation Treatment _____
Y N Rheumatic Fever_____
Y N Scarlet Fever_____
Y N Seizures_____
Y N Sleep Apnea_____
Y N Snoring_____
Y N Sinus Problems_____
Y N Stroke_____
Y N Thyroid Problems_____
Y N Tuberculosis (TB)_____
Y N Ulcers_____
Y N Venereal Disease_____
Y N Other:_____
Explain any of the above:_____
_____

Are you allergic to any of the following?

Y N Latex	Y N Erythromycin	Y N Anesthetics
Y N Codeine	Y N Penicillin	Y N Pets
Y N Aspirin	Y N Tetracycline	Y N Other

Please List:_____

MEDICAL HISTORY (cont'd)

Do you have a personal Physician? ☐Y ☐N
Physician's Name:_____
Phone#:(_____)_____-_____ Last visit:____/____/____
Are you currently receiving Treatment? ☐Y ☐N
Please explain:_____
Your Current Physical Health is: ☐ Good ☐ Fair ☐ Poor
Do you smoke, or use tobacco in any form? ☐Y ☐N
If yes, what type:_____
Do you use an e-cig or vape? ☐Y ☐N
Do you have any metal plates, pins, or rods? ☐Y ☐N
Have you had a joint replacement? ☐Y ☐N
If so, when:_____
Have you ever taken IV/oral bisphosphonates? (aka Fosamax, Activa, Boniva)
☐ Yes ☐ No If so, when?_____
Are you taking any prescription medications, over-the-counter medications, or herbal supplements?
☐ Yes ☐ No
Please list each one (or provide a list):

_____ _____
_____ _____
_____ _____

Women: Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant or trying to become pregnant? ☐Yes
☐No If so, Week#_____

Are you nursing? ☐ Yes ☐ No

DENTAL HISTORY

What brings you to the dentist today?_____
_____
Previous/Present Dentist:_____
Last Visit Date:_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Are you currently in pain? ☐ Yes ☐ No
Have you ever had a serious/ difficult problem associated with dental work? ☐ Yes ☐ No
Have you ever had gum treatment? ☐ Yes ☐ No
Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/ TMD)? ☐ Yes ☐ No
Your current dental health is ☐ Good ☐ Fair ☐ Poor
Do your gums ever bleed? ☐ Yes ☐ No
How often do you brush_____floss_____
Type of bristles ☐ Hard ☐ Medium ☐ Soft
How often do you replace your toothbrush?_____
Are any of your teeth sensitive? ☐ Yes ☐ No
If so, to what?_____
Have you lost any teeth? ☐ Yes ☐ No Why?_____
Do you like your smile? ☐ Yes ☐ No
If No, then what would you like changed?_____
_____

HIPAA

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I have received a copy of Lakeview Dental's Notice of Privacy Practices.

Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been agreed upon.

I understand that as a courtesy to me, Lakeview Dental will file to my insurance provider. I understand that I am responsible for payment of services rendered and also for paying any co-payment or deductibles that my insurance does not cover. I hereby authorize payment directly to Lakeview Dental for the group benefits otherwise payable to me. I hereby authorize the release of any information, including the diagnosis and records of treatment rendered, to my insurance company. I understand that I am personally responsible for all costs of dental treatment at time of service.

Signature Date

I testify that the information given today is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status.

Signature Date

DOCTOR USE ONLY

I have verbally reviewed the patient's medical / dental information

_____ _____
Signature Date