Lakeshore Dental sc

Welcome

Please fill out this form completely, it is important to your dental care.
We strive to provide you with the best possible dental care.

About You

Today's Date: _____ ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Name: _____ ☐ M ☐ F
First Middle Last Nickname

Birthdate: ____/____/____ Age: _____ SS # _____

Home Address: _____

Hm # (____) _____ Cell # (____) _____ Wk # (____) _____

E-Mail Address: _____ When are the best times to reach you? _____

Whom may we thank for referring you? _____ Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____

General Dentist: _____ Previous or Present (Please circle) Date of last visit: _____

Who should we contact in case of emergency?

His/Her Name: _____ Relation: _____

Cell # (____) _____ Wk # (____) _____ Hm# (____) _____

Address: _____

Spouse Information

His/Her Name: _____ Birthdate: ___/___/___ SS # _____

Employer: _____ Wk # (____) _____ Cell # (____) _____

Person Responsible for Account, if other than yourself

Name: _____ Relation: _____ SS # _____

Employer: _____ Wk # (____) _____ Cell # (____) _____

Hm # (____) _____ Billing Address: _____

Insurance Information

Primary Insurance Dental Coverage: ☐ Y ☐ N Medical Coverage: ☐ Y ☐ N Orthodontic Coverage: ☐ Y ☐ N

Insurance Co. Name: _____ Ins. Co. Ph # (____) _____

Ins. Co. Address: _____ Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____ Insured's Birthdate: ___/___/___ SS # _____

Insured's Employer: _____ Employer's Address: _____

Secondary Insurance Dental Coverage: ☐ Y ☐ N Medical Coverage: ☐ Y ☐ N Orthodontic Coverage: ☐ Y ☐ N

Insurance Co. Name: _____ Ins. Co. Ph # (____) _____

Ins. Co. Address: _____ Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____ Insured's Birthdate: ___/___/___ SS # _____

Insured's Employer: _____ Employer's Address: _____

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? ☐ Y ☐ N

Do you require antibiotics before dental treatment? ☐ Y ☐ N

Have you experienced problems associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort in your jaw (TMJ/TMD)? ☐ Y ☐ N

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Y ☐ N

Do you brush daily? ☐ Y ☐ N

Type of bristles on toothbrush: ☐ Hard ☐ Medium ☐ Soft

How often do you replace your toothbrush? _____

Do you use anything in addition to your brush and floss? ☐ Y ☐ N

If yes, what? _____

Would you like fresher breath? ☐ Y ☐ N

Whiter teeth? ☐ Y ☐ N

Do your gums bleed? ☐ Y ☐ N

Do gums itch? ☐ Y ☐ N

Do you have mobility in your teeth? ☐ Y ☐ N

Are your teeth sensitive to heat, cold or anything else? _____

Do you still have wisdom teeth? ☐ Y ☐ N

Previous Dentist: _____ Date of last visit: _____

Why did you leave your previous dentist? _____

What did you like most/least about any dentist you have seen?

_____

Are you happy with the way your smile looks? ☐ Y ☐ N

If not, what would you change? _____

Medical History

Do you have a personal physician? ☐ Y ☐ N

Physician's Name: _____

Address: _____

_____

Phone #: (_____) _____

Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: _____

Do you smoke or use tobacco in any form? ☐ Y ☐ N

Are you allergic to any of the following? (Please check box)

Aspirin	☐ Y	☐ N	Latex	☐ Y	☐ N
Barbiturates	☐ Y	☐ N	Penicillin	☐ Y	☐ N
Codeine	☐ Y	☐ N	Sedatives	☐ Y	☐ N
Dental Anesthetics	☐ Y	☐ N	Sulfa Drugs	☐ Y	☐ N
Erythromycin	☐ Y	☐ N	Tetracycline	☐ Y	☐ N
Jewelry / Metals	☐ Y	☐ N	Other	☐ Y	☐ N

Please list additional drugs / materials that cause allergic reactions:

_____

WOMEN: Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Unsure ☐ Y ☐ N Week #_____

Are you nursing? ☐ Y ☐ N

Are you taking any of the following?

☐ Acetaminophen	☐ Digitalis / Heart Medication
☐ Antibiotics	☐ Insulin / Diabetes Drugs
☐ Antihistamines	☐ Nitroglycerin
☐ Aspirin	☐ Recreational Drugs
☐ Blood Thinners	☐ Steroids / Cortisone
☐ Blood Pressure Medication	☐ Thyroid Medicine
☐ Cold Remedies	☐ Tranquilizers

Have you ever taken Phen-Fen (Redux or Pondimin)? ☐ Y ☐ N

Are you currently taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ☐ Y ☐ N

If yes, please list each one _____

_____

_____

_____

_____

_____

Please check the yes or no if you have or have ever had any of the following diseases or medical problems.

Abnormal Bleeding	☐ Y	☐ N	Colitis	☐ Y	☐ N	Headaches	☐ Y	☐ N	Liver Disease	☐ Y	☐ N	Shingles	☐ Y	☐ N
Alcohol Abuse	☐ Y	☐ N	Congenital Heart Defect	☐ Y	☐ N	Heart Attack	☐ Y	☐ N	Low Blood Pressure	☐ Y	☐ N	Sickle Cell Disease	☐ Y	☐ N
Anemia	☐ Y	☐ N	Diabetes	☐ Y	☐ N	Heart Murmur	☐ Y	☐ N	Lupus	☐ Y	☐ N	Sinus Problems	☐ Y	☐ N
Arthritis	☐ Y	☐ N	Difficulty Breathing	☐ Y	☐ N	Heart Surgery	☐ Y	☐ N	Mitral Valve Prolapse	☐ Y	☐ N	Steroid Therapy	☐ Y	☐ N
Artificial Bones / Joints	☐ Y	☐ N	Drug Abuse	☐ Y	☐ N	Hemophilia	☐ Y	☐ N	Osteoporosis	☐ Y	☐ N	Stroke	☐ Y	☐ N
Artificial Valves	☐ Y	☐ N	Emphysema	☐ Y	☐ N	Hepatitis	☐ Y	☐ N	Pacemaker	☐ Y	☐ N	Thyroid Problems	☐ Y	☐ N
Asthma	☐ Y	☐ N	Epilepsy	☐ Y	☐ N	Herpes	☐ Y	☐ N	Persistent Cough	☐ Y	☐ N	Tonsillitis	☐ Y	☐ N
Blood Transfusion	☐ Y	☐ N	Fainting Spells	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N	Psychiatric Problems	☐ Y	☐ N	Tuberculosis (TB)	☐ Y	☐ N
Cancer	☐ Y	☐ N	Fever Blisters	☐ Y	☐ N	HIV+/AIDS	☐ Y	☐ N	Radiation Treatment	☐ Y	☐ N	Ulcers	☐ Y	☐ N
Chemotherapy	☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Hospitalized for Any reason	☐ Y	☐ N	Scarlet Fever	☐ Y	☐ N	Venereal Disease	☐ Y	☐ N
Chicken Pox	☐ Y	☐ N	Hay Fever	☐ Y	☐ N	Kidney Problems	☐ Y	☐ N	Seizures	☐ Y	☐ N			

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. **PAYMENT IS DUE AT TIME OF SERVICE.**

My method of payment will be _____ Signature _____ Date _____

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____ Date _____

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.