

Name Last		First	Middle
Address Street and P.O. Box		City	State Zip Code Phone #s: Home: Work: Cell: Pager
Age:	Birth Date	Mo. Day Year	() Married () Unmarried () Separated
Social Security #		Occupation	Employer
Person Responsible for bill		Address (leave blank if same as above) Relationship	
Insured Person's Full Name		Date of Birth	Social Security #
Subscriber ID#		Work Phone	
Group Id #		Relationship to Patient	
Insurance Company Name		() Insurance Co. Phone #	Insurance Co. Address
Employer Name		Full Address of Employer	
1. What is the reason for your visit?		7. When was your last dental visit?	
2. Are you interested in anxiety free dentistry?		8. When was the last time you had a complete dental radiographs taken?	
3. Why did you select our practice?		9. Name and Address Of Last Dentist?	
4. Whom may we thank for referring you?		10. Have you ever had teeth removed?	
5. Is another member of your family or relative a Patient in our practice?		11. How long have these teeth been missing ?	
6. Person to contact for emergency Phone: _____		12. Have these teeth been replaced? How? <input type="checkbox"/> Bridge <input type="checkbox"/> Partial <input type="checkbox"/> Denture <input type="checkbox"/> Implants	
Please check appropriate box:			
<input type="checkbox"/> 1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance		This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason does not honor their commitment to us.	
<input type="checkbox"/> 2. Cash and personal checks are accepted as your treatments are provided.		<input type="checkbox"/> 4. MasterCard, Visa, Discover, Care Credit	
<input type="checkbox"/> 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment: another service to you.		<input type="checkbox"/> 5. For long term or extended payments we offer a financing program, which when you are accepted, allow extended small monthly payments for the received.	

FOR ALL PATIENTS: I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature _____

Under the HIPPA Act of 1996, I am informed of the form *Notice of Privacy Policies* from Lakeview Dental

Signature _____ Date _____

Medical History- Please check Yes or No

How do you feel about getting and maintaining a healthy mouth? _____

Do you drink soda pop? How much?

Do you have an unpleasant taste or odor in your mouth?

Are your teeth sensitive to hot, cold, or sweets?

Are you having dental problems at this time?

Do your gums bleed at any time?

Do you feel very nervous about having dental treatment?

Have you ever had a bad experience in the dental office?

Have you been under the care of a medical doctor during the last two years?

If yes, for what reason? _____

Please provide the name, address, and phone number of your physician.

Have you been a patient in the hospital during the past two years?

If yes, for what reason? _____

Have you taken medicine or drugs during the last two years? If yes please list: _____

Are you allergic to (i.e., itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, latex, aspirin, codeine, or any drugs or medicines? If yes, please list; _____

Have you ever had excessive bleeding requiring special treatment?

Do you use tobacco products?

Does your jaw pop or lock?

Have you had braces?

Are you allergic to local anesthetic?

Do you brush your teeth/How often/ Use fluoride? _____

Check any of the following which apply either past or present:

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Valve prolapse | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cortisone Medication |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pain in jaw joints |
| <input type="checkbox"/> Family History of Cardiovascular Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> X-ray or Cobalt Treatment |
| <input type="checkbox"/> Angina Pectoris (chest pain) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cancer or Tumors |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> HIV Positive (AIDS) |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Artificial Joint of Any Type | <input type="checkbox"/> Any for of Eating Disorder | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Diet Medication: Name: _____ | <input type="checkbox"/> Recreational Drug Use | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Drug Addicts/Alcoholism | <input type="checkbox"/> Diabetes – Type _____ |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Any Form of Tuberculosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Birth Control |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Pregnant- Due Date _____ |
| | <input type="checkbox"/> Headaches | |

Do you have any disease, condition or problem not listed? If so, please list: _____
