

# WELCOME

## Lakeside Cosmetic & Family Dentistry

### *Patient Information:*

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (mark preferred)  Home: \_\_\_\_\_  Work: \_\_\_\_\_  Cell: \_\_\_\_\_

Sex: M / F Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_  Single  Married  Divorce  Widowed

Email: \_\_\_\_\_

Patient Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone: \_\_\_\_\_

### *Primary Insurance:*

Person Responsible for Account: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_

Person Responsible Employed By: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

### *Additional Insurance:*

Subscriber Name: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

### *Authorization and Release:*

I authorize my insurance company to pay to Dr. Heap or Dr. Snell all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Dr. Heap & Dr. Snell may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services, as pertaining to the HIPAA guidelines.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*Dental History:*

Reason for Today's Visit: \_\_\_\_\_

Date of Last Dental Cleaning: \_\_\_\_\_ Date of Last Dental X-Rays: \_\_\_\_\_

Mark if you have had problems with any of the following:

- |                                                        |                                                   |                                                         |
|--------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Jaw Pain                 | <input type="checkbox"/> Sensitivity to Hot             |
| <input type="checkbox"/> Bleeding Gums                 | <input type="checkbox"/> Loose or Broken Teeth    | <input type="checkbox"/> Sensitivity when Biting        |
| <input type="checkbox"/> Clicking or Popping Jaw       | <input type="checkbox"/> Loose or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets          |
| <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Periodontal Treatment    | <input type="checkbox"/> Sores or Growths in your Mouth |
| <input type="checkbox"/> Grinding Teeth                | <input type="checkbox"/> Sensitivity to Cold      |                                                         |

Is there anything you would like to change about the appearance of your smile? \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

*Medical History:*

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you had any serious illnesses or operations? Yes / No If yes, describe: \_\_\_\_\_

Have you ever had a blood transfusion? Yes / No If yes, give approximate dates: \_\_\_\_\_

Has it ever been necessary for you to pre-medicate for dental appointments? Yes / No If yes, describe: \_\_\_\_\_

Mark if you have or have had any of the following:

- |                                                  |                                               |                                                |                                                     |
|--------------------------------------------------|-----------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis _____       | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> HIV / AIDS            | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |

Women: Are you pregnant? Yes / No Nursing? Yes / No Taking birth control pills? Yes / No

Medications

List medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies

List any allergies you are aware of:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Snell, Dr. Heap or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_