LAKEVIEW DENTAL CARE

Dental Registration and History

Patient Information

Date:_____

SS/HIC/Patient ID #: _____

Patient Last Name:_____

First Name:_____Middle Initial:_____

Address:_____

City:_____

State:_____Zip:_____

E-mail:_____

Sex: ☐ M ☐ F Age:_____Birthdate:_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Seperated ☐ Divorced ☐ Partnered for____years

Occupation:_____

Patient Employer/School:_____

Employer/School Address:_____

_____

Employer/School Phone:_____

Spouse's Name:_____

Birthdate:_____

SS#:_____

Spouses Employer:_____

Whom may we thank for referring you?

☐ TV Commercial ☐ Clipper Magazine

☐ Atlantic City Press ☐ Yellow Pages

☐ Website ☐ Internet/Google

☐ Car Wrap ☐ Share A Smile

☐ Facebook ☐ Twitter

☐ Direct Mail

☐ Patient Referral_____

☐ Dr. Referral_____

☐ Insurance Participation_____

☐ Other_____

Dental Insurance

Who is responsible for this account?_____

Relationship to Patient?_____

Insurance Co._____

Group #:_____

Is Patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name:_____

Birthdate:_____SS#:_____

Relationship to Patient:_____

Insurance Co._____

Group #:_____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with_____and assign directly to Dr._____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent Guardian or Personal Representative

_____

Date Relationship to Patient

Phone Numbers

Home: (_____)_____Work: (_____)_____

_Ext:_____Cell Phone: (_____)_____

Spouses Work:_____

Best time and place to reach you:_____

IN CASE OF EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name:_____

Relationship:_____

Home Phone:(_____)_____

Work Phone:(_____)_____

- OVER -

Dental History

Reason for today's visit:_____

_____

Former dentist:_____

City/State:_____

Date of last dental visit:_____

Date of last dental x-rays:_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Clicking or popping jaw	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Dry mouth	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Food collection between teeth	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Lip or cheek biting	☐ Yes	☐ No	How often do you floss?_____		
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush?_____		

Health History

Physician's name:_____Date of last visit:_____

Have you ever taken any of the group of drugs collectively referred to as "Fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet fever	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart problems	☐ Yes	☐ No	Skin rash	☐ Yes	☐ No
Back problems	☐ Yes	☐ No	Hepatitis type _____	☐ Yes	☐ No	Special diet	☐ Yes	☐ No
Bleeding abnormally,			Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
with extractions or surgery	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No	Swollen feet or ankles	☐ Yes	☐ No
Blood disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen neck glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw pain	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Chemical dependency	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory problems	☐ Yes	☐ No	Low blood pressure	☐ Yes	☐ No	Tumor or growth on head		
Congenital heart lesions	☐ Yes	☐ No	Mitral valve prolapse	☐ Yes	☐ No	or neck	☐ Yes	☐ No
Cortisone treatments	☐ Yes	☐ No	Nervous problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric care	☐ Yes	☐ No	Weight loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation treatment	☐ Yes	☐ No	Do you wear contact lenses?	☐ Yes	☐ No

WOMEN:

Are you nursing?	☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No	Due date:_____		
			Taking birth control pills?	☐ Yes	☐ No			

Medications

List any medications you are currently taking and the correlating diagnosis:_____

_____

_____

Pharmacy name:_____

Phone: (_____)_____

Allergies

☐ Asprin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Latex
☐ Other:_____

_____

_____

Lakeview Dental Care requires 48 hours notice for any cancellations or changes in our schedule. We reserve the right to charge $100 per appointment if required notice is not given.

_____
Signature