Lakeside Dental
COMMITMENT TO CARE

PATIENT INFORMATION

Today's Date: ____/____/____
PATIENT'S NAME: _____ **Preferred Name**: _____
FIRST MI LAST

(If you are completing this form for another person): Your Name: _____ Relation: _____

DATE OF BIRTH: _____ **AGE:** ____ **SEX:** M F **SOCIAL SECURITY #:** _____

ADDRESS: _____
Mailing and Street Address city/state zip

Phone (home):_____ **Phone (work):**_____ **Phone (cell):** _____
Best time to call: _____ **Email:** _____

PREFERED COMMUNICATION FOR APPOINTMENT REMINDERS: **EMAIL** **TEXT** **PHONE** **(H W C)**

Employer/School: _____ Occupation: _____ Spouse's Name: _____
Employer Address: _____
Street city/state zip

DENTAL INSURANCE: YES NO
Subscriber Name:_____SS#_____D.O.B._____Relation:_____

RESPONSIBLE PARTY (Person responsible for account if different than above)
Name: _____ Relationship: _____ Ph (home):_____ Ph (work):_____
Address: _____
Street City/State Zip

EMERGENCY CONTACT
Whom should we contact? _____ Relation: _____ Phone #: _____

Were you referred to our office? By whom: _____

Please turn off cell phones. Thank you.

DENTAL AND ORAL HEALTH

What is the primary reason for your visit today? _____
Are you currently in pain? Y or N
Describe any previous problems you may have had with past dental treatment or special areas of concern you would like to have addressed by Dr. Bushnell and his staff. _____
_____
_____
_____
When was your last dental visit? _____How often do you have dental exams?_____
When do you usually brush? _____ Floss? _____
Have you ever used Nitrous Oxide at a dental visit? Y or N
Do you have any apprehension regarding your visit? □Fear □Time □Money □Tension
Your current *dental* health is: □Good □Fair □Poor
Are you happy with how your smile looks? Y or N If not, what would you like to change? _____

Please indicate any of the following concerns and any previously treated dental conditions:

□ Teeth that are sensitive:
□ Air □ Cold □ Hot □ Biting
□ Broken/Chipped teeth
□ Lost/Broken fillings
□ Missing teeth
□ Stained/Dark teeth
□ Discomfort in jaw joint (TMJ)
□ Difficulty opening or moving jaw
□ Clenching or grinding teeth
□ Orthodontics / "Braces"
□ Oral/Jaw surgery
□ Oral cancer
□ Unpleasant taste/persistent bad breath
□ Bleeding or sore gums
□ Periodontal disease or "deep" cleanings
□ Food catching between teeth
□ Blisters/Sores in or around the mouth
□ Other: _____

Have you ever suffered head and neck trauma? Y or N

MEDICAL HISTORY

Are you allergic to - or have you had a bad reaction to - any of the following?
□Latex
□Penicillin
□Tetracycline
□Sulfa Drugs
□Aspirin/Ibuprofen
□Codeine
□Dental Anesthetics
□Jewelry/Metal
□Foods:_____
□Other: _____

Please list any medications you are taking:
(Or provide a complete list to the receptionist).
_____
_____
_____
_____
_____
Do these include: □Blood Thinners □Insulin
□Bisphosphonate (Osteoporosis meds)
□Pain Killers □Sedatives
OTC (over-the-counter) meds: _____
Vitamins/Supplements: _____
_____

What is your preferred pharmacy? _____

How would you rate your current health?
□Good □Fair □Poor

Do you smoke or use tobacco? Y or N
Have you abused drugs in the past? Y or N

Are you pregnant? Y or N Week # _____
Nursing? Y or N

Do you require antibiotics before dental treatment?
Y or N

Do you have a personal physician? Y or N
If so, Physician's Name: _____
Phone: _____
Reason of last visit: _____

Have you ever had any of the following diseases or medical problems?

Y N….Anemia	Y N….Hemophilia
Y N….Arthritis	Y N….Hepatitis _____
Y N….Artificial Joints/Valves	Y N….High Blood Pressure
Y N….Asthma	Y N…. Low Blood Pressure
Y N….Back Problems	Y N….HIV/AIDS
Y N….Breathing Difficulty	Y N….Kidney disease
Y N….Bruise Easily	Y N….Liver disease
Y N….Cancer	Y N….Migraine/Headaches
Y N….Chemotherapy	Y N….Mitral Valve Prolapse
Y N….Chest Pain	Y N….Organ Transplant
Y N….Congenital Heart Defect	Y N….Pacemaker
Y N….Cosmetic Surgery	Y N….Psychiatric Problems
Y N….Diabetes: type_____	Y N….Radiation Therapy
Y N….Dry Mouth	Y N….Respiratory problems
Y N….Eating Disorder	Y N….Seizures
Y N….Emphysema	Y N….Shingles
Y N….Epilepsy	Y N….Sinus problems
Y N….Excessive Bleeding	Y N….STD
Y N….Fainting/Dizziness	Y N….Steroid Treatment
Y N….Head Injury	Y N….Stroke
Y N….Hearing Loss/Deafness	Y N….Thyroid or Adrenal
Y N….Heart Attack	Y N….Tuberculosis TB
Y N….Heart Disease	Y N….Ulcers
Y N….Heart Murmur	Y N….Glaucoma

Have you ever experienced prolonged or excessive bleeding?
Y or N
Please list any other serious medical condition: _____
_____
_____
Is there ANY other information you would like us to be aware of? _____
_____
_____

CONSENT – To the best of my knowledge, all of the preceding information is correct. If there is ever any change to this medical status, this practice will be informed without fail. I understand this information will be held in the strictest confidence and will not be shared with anyone outside the office without written consent that is signed and dated. I do authorize the release of all information necessary to secure the payment of benefits. I hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual. I also authorize the use of anesthesia and/or other medication necessary for dental treatment to be rendered by the dental staff.

Signature: _____ Date: _____

OFFICE USE: UPDDATES

Date	Initials
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____