welcome

About You

Today's Date: _____ E-Mail Address: _____

Name: Prefer to be called: _____
Last First MI Mr. Mrs. Ms. Dr.

Birthdate: _____ Age: _____ ☐ M ☐ F Social Security #: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Home Address: _____
Street /PO Box City State Zip

Home Phone#: _____ Cell/Other#: _____ Work#: _____

Where and when are best times to reach you? _____

How to confirm appointments?: ☐ E-mail ☐ Cell ☐ Text ☐ Home ☐ Work

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

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative Not Living with You

Name: _____ Relation: _____ Work #: _____ Home #: _____

Address: _____
Street /PO Box City State Zip

Spouse/Partner Information

His/Her Name: _____ Birthdate : _____ Social Security #: _____

Employer: _____ Work #: _____ Cell #: _____

Insurance Information

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

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local, Policy#): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's SS#: _____ Insured's DOB: _____

Relation: _____ Insured's Employer: _____

Employer's Address: _____
Street /PO Box City State Zip

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

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local, Policy#): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's SS#: _____ Insured's DOB: _____

Relation: _____ Insured's Employer: _____

Employer's Address: _____
Street /PO Box City State Zip

Dental History

Why have you come to the dentist today?_____

Are you currently in pain? ☐ Y ☐ N

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

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

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

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

Do you still have your wisdom teeth? ☐ Y ☐ N

Do you floss daily? ☐ Y ☐ N Brush Daily? ☐ Y ☐ N

Type of bristles on your toothbrush? ☐ Hard ☐ Med ☐ Soft

Previous/Present Dentist:_____ Last dental visit:_____

Do your gums ever bleed? ☐ Y ☐ N

Pain in jaw joints? ☐ Y ☐ N

Have you ever had periodontal disease? ☐ Y ☐ N

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Medical History

Do you have a personal physician? ☐ Y ☐ N

Physician's Name:_____

Physician's Address:_____
City State

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

If yes, please explain:_____

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

Have you ever taken Fosamax or any other bisphosphonate? ☐ Y ☐ N

Phone #:_____ Date of Last Visit:_____

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

Preferred Pharmacy:_____

For Women:

Are you taking birth control? ☐ Y ☐ N

Are you Pregnant? ☐ Unsure ☐ Y ☐ N

Week# Nursing? ☐ Y ☐ N

Do you or have you experienced the following?

☐ Y ☐ N AIDS/HIV	☐ Y ☐ N Cold Sores/Fever Blisters	☐ Y ☐ N Heart Surgery	☐ Y ☐ N Radiation Treatment
☐ Y ☐ N Abnormal Bleeding	☐ Y ☐ N Colitis	☐ Y ☐ N Hemophilia	☐ Y ☐ N Renal Dialysis
☐ Y ☐ N Alcohol Abuse	☐ Y ☐ N Congenital Heart Disorder	☐ Y ☐ N Hepatitis A B C	☐ Y ☐ N Rheumatic Fever*
☐ Y ☐ N Alzheimer's Disease	☐ Y ☐ N Type I or II Diabetes	☐ Y ☐ N Herpes	☐ Y ☐ N Rheumatism
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Drug Addiction	☐ Y ☐ N High Blood Pressure	☐ Y ☐ N Scarlet Fever
☐ Y ☐ N Anemia	☐ Y ☐ N Emphysema/Breathing Difficulty	☐ Y ☐ N High Cholesterol	☐ Y ☐ N Sickle Cell Disease
☐ Y ☐ N Angina	☐ Y ☐ N Epilepsy/Seizures	☐ Y ☐ N Hypoglycemia	☐ Y ☐ N Sinus Problems
☐ Y ☐ N Arthritis	☐ Y ☐ N Excessive Bleeding	☐ Y ☐ N Kidney Problems	☐ Y ☐ N Spina Bifida
☐ Y ☐ N Artificial Bones/Joints*	☐ Y ☐ N Excessive Thirst	☐ Y ☐ N Leukemia	☐ Y ☐ N Steroid Therapy
☐ Y ☐ N Artificial Valves*	☐ Y ☐ N Fainting Spells/Dizziness	☐ Y ☐ N Liver Disease	☐ Y ☐ N Stroke
☐ Y ☐ N Asthma	☐ Y ☐ N Frequent Headaches	☐ Y ☐ N Low Blood Pressure	☐ Y ☐ N Thyroid Disease
☐ Y ☐ N Blood Transfusion	☐ Y ☐ N Glaucoma	☐ Y ☐ N Lupus	☐ Y ☐ N Tonsillitis
☐ Y ☐ N Cancer	☐ Y ☐ N Hay Fever	☐ Y ☐ N Mitral Valve Prolapse*	☐ Y ☐ N Tuberculosis
☐ Y ☐ N Chemotherapy	☐ Y ☐ N Heart Attack/Failure/Problems	☐ Y ☐ N Pacemaker	☐ Y ☐ N Ulcers
☐ Y ☐ N Chicken Pox/Shingles	☐ Y ☐ N Heart Murmur*	☐ Y ☐ N Psychiatric Problems	☐ Y ☐ N Venereal Disease

*By checking these health conditions, be aware that you may need dental antibiotic premedication_____ (initial) If not, a written release from a treating physician is necessary. _____ (initial)

Please list any serious medical condition(s) that you have experienced:_____

Are you taking any prescription/over the counter drugs? ☐ Y ☐ N If yes, please list each one:_____

Are you allergic (itching/swelling/hives) to any of the following?_____

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

Please list anything additional that causes allergic reactions:_____

HIPAA (PATIENT)

May we have permission to leave a message at your: Home ☐ Y ☐ N Work ☐ Y ☐ N Cell # ☐ Y ☐ N

Best number to use: ☐ Home ☐ Work ☐ Cell Phone ☐ Other: _____ E-mail Address:_____

Discuss your treatment/account with anyone? ☐ Y ☐ N If yes, Name/Relationship/Phone#: _____

☐ I have received the Lighthouse Dental Privacy Notice. ☐ I agree to e-mail communications with Lighthouse Dental (Information will not be sold or shared with entities outside of Lighthouse Dental)

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services that I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature_____ Date_____