Welcome

DATE: _____ **PATIENT INFORMATION**

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. _____ (Last Name) _____ (First Name) _____ (Initial)

Home Phone: _____ Cell Phone: _____ Email: _____

Soc. Sec. # _____ Sex: ☐ M ☐ F Age: _____ Birthdate: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____

In case of emergency, who should be notified? _____ Phone: _____

Whom may we thank for referring you? _____ Hobbies: _____

PRIMARY DENTAL INSURANCE

Primary person insured: _____ (*Last Name*) _____ (*First Name*) _____ (*Initial*)

Relation to Patient: _____ Birthdate of insured _____ Phone: _____

Address (if different from patient's) _____

City: _____ State: _____ Zip: _____

Employer of Person Responsible: _____ Occupation: _____

Employer Address: _____ Business Phone: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Group # _____ Subscriber (Soc. Sec. #) _____

Address: _____ City: _____ State: _____ Phone: _____

ADDITIONAL DENTAL INSURANCE

Subscriber name: _____ Relation to Patient: _____ Birthdate: _____

Address (if different from patient's) _____

City: _____ State: _____ Zip: _____

Subscriber Employer Address: _____ Business Phone: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Group # _____ Subscriber (Soc. Sec. #) _____

Address: _____ City: _____ State: _____ Phone: _____

OVER ➔

DENTAL HISTORY

Reason for Today's visit: _____

Former Dentist: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

Check (✓) if you have/had any of the following:

- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding Teeth/Clenching
- ☐ Periodontal treatment
- ☐ Sensitivity to hot/cold/pressure
- ☐ Sores or growths in your mouth

How often do you brush? _____ How often do you floss? _____

MEDICAL HISTORY

Physician's Name: _____

Have you had any serious illness or operations? ☐ Yes ☐ No If yes, describe _____

Do you smoke or use tobacco products? ☐ Yes ☐ No If yes, what do you smoke? _____ How many a day? _____ For how long? ___

Do you or have you used controlled substance? ☐ Yes ☐ No

(Women Only ☺) Are you pregnant or think you might be? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

No Are you nursing? ☐ Yes ☐ No

Check (✓) if you have/had any of the following:

- ☐ Abnormal blood press.
- ☐ AIDS or HIV
- ☐ Allergies
- ☐ Alzheimer's or dementia
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Autism
- ☐ Back Problems
- ☐ Blood transfusion
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cold sores or fever blisters
- ☐ Congenital heart lesions
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Eating disorders
- ☐ Epilepsy or seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis Type: _____
- ☐ High Blood Pressure
- ☐ Joint replacement or implant
- ☐ Kidney trouble
- ☐ Lymph node enlargement
- ☐ Mental Health Care
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Shortness of breath
- ☐ Skin Rash
- ☐ STD
- ☐ Stroke
- ☐ Swelling of feet/ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis/lung dis.
- ☐ Ulcers
- ☐ Other, Please list

_____

_____

MEDICATIONS:

List medications you are currently taking:

1)_____ TAKEN FOR_____

2)_____ TAKEN FOR_____

3)_____ TAKEN FOR_____

Are you allergic to or have you had reactions to:

Latex/Rubber	Yes No	Pain Medications	Yes No	Sulfa Drugs	Yes No
Penicillin or other antibiotics	Yes No	Aspirin	Yes No	Other (please list) _____	

FOR DENTAL INSURED PATIENTS ONLY

I authorize my insurance company to pay Louisville Family Dental all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Louisville Family Dental to release all information necessary to secure the payment of benefits. I agree to pay any estimated amount not to be paid by insurance on day of treatment and understand that this is only an estimate. I understand insurance may not pay 100% for all procedures and that I am 100% responsible for any amount not paid by insurance.

Signature: _____ Date: _____

Dentist reviewed health history _____ Date: _____