WELCOME TO LIFETIME DENTAL

PATIENT INFORMATION			
Patient:		**Today's Date:**	
SS#:		Address:	
Birthdate:		City:	State: Zip:
Sex: ☐ M ☐ F	Age:	Spouse's name:	
☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ——— years		Spouse's birthdate:	
		Spouse's Employer:	SS#:
Occupation:		Who may we thank for referring you?	
Patient Employer/School:		Employer/School Address:	

CONTACT INFORMATION		INSURANCE INFORMATION
Cell #:	Email:	I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Lifetime Dental 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 doctor may use my health care information and may disclose such information to my insurance company 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 below. Name of insurance company: _____ Subscriber's name: _____ Date: _____ Signature of parent or responsible party:
Home #:	Emergency contact (name and relationship to patient)	
Work #:	Emergency contact #:	

DENTAL INFORMATION	
Do your gums bleed when you brush or floss?	☐ Yes ☐ No
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐ Yes ☐ No
Is your mouth dry?	☐ Yes ☐ No
Have you had any periodontal (gum) treatment?	☐ Yes ☐ No
Have you ever had orthodontic (braces) treatment?	☐ Yes ☐ No
Have you had any problems associated with previous dental treatment?	☐ Yes ☐ No
Is your home water supply fluoridated?	☐ Yes ☐ No
Do you drink bottled or filtered water? (If yes, how often? ☐ Daily / ☐ Weekly / ☐Occasionally)	☐ Yes ☐ No
Are you currently experiencing dental pain or discomfort?	☐ Yes ☐ No
Do you have any earaches or neck pain?	☐ Yes ☐ No
Do you brux or grind your teeth?	☐ Yes ☐ No
Do you have any clicking, popping, or discomfort in the jaw?	☐ Yes ☐ No
Do you have sores or ulcers in your mouth?	☐ Yes ☐ No
Do you wear dentures or partials?	☐ Yes ☐ No
Do you participate in active recreational activities?	☐ Yes ☐ No
Have you ever had a serious injury to your head or mouth?	☐ Yes ☐ No

Date of your last dental exam?	What was done at that time?
What is the reason for your visit today?	Date of last dental x-rays?
How do you feel about your smile?	Any concerns to discuss today?

-**PLEASE TURN OVER TO COMPLETE FORM-**

HEALTH HISTORY

Primary care physician name:	Previous Dentist	
Primary care physician phone #:	Name:	Phone#:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cough; persistent or bloody	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No			
Emphysema	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			

WOMEN ONLY

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

MEDICATIONS
List any medications you are currently taking.

_____

_____

_____

Pharmacy name: _____ Phone: ( ) _____

ALLERGIES

☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Other
☐ Latex	☐ NONE
☐ Local Anesthetic	_____

UPDATES: To be filled out by our staff, please do not write in this box.

_____

_____

_____

-**THANK YOU-**