Welcome

We would like to welcome you to our dental office and thank you for choosing us as your dental healthcare team. The benefits of a healthy, happy smile are immeasurable! Our goal is to help you reach and maintain **excellent oral health**. Please fill out the following information completely. The better we communicate, the better we can care for you. All information is confidential.

Personal History

Today's Date _____ Patient SS# _____

Patient Name _____ Nickname _____ _____
Address _____ Home Phone _____
_____ Cell Phone _____
City _____ State _____ Zip _____ Birth Date _____
Male _____ Female _____ **Email** _____
Check one: Minor ____ Single ____ Married ____ Divorced ____ Widowed ____
Spouses Name _____ Birth date _____ SS# _____

Your Employer _____ Spouse Employer _____
Address _____ Address _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Work Phone: _____ Work Phone _____
Person Financially Responsible _____ Relationship to patient _____

If patient is a child:

Mother's name _____ Father's name _____
Whose address is different from above? _____ ____ Mother ____ Father _____N/A
Address _____
City _____ State _____ Zip _____ Telephone: _____

In the event of an emergency, who should we contact?_____
Relationship: _____ Telephone: _____

Dental Insurance Information

Do you have dental insurance? YES NO **Does your spouse have dental insurance?** YES NO
Whose insurance is primary for your children? _____ Birth Dates and Social Security Numbers are required.

Primary Dental Ins. Company _____ Primary SS# _____
Primary Birth Date _____ Relationship to Patient _____
Primary Employer _____ Group plan #_____ ID#_____
Employer Address: _____ City _____ State _____ Zip _____
Secondary Dental Ins. Company _____ Secondary SS# _____
Secondary Birth Date _____ Relationship to Patient _____
Secondary Employer _____ Group plan #_____ ID#_____
Employer Address: _____ City _____ State _____ Zip _____

Dental History

When was your last visit to a dentist? _____ What was done? _____
May we contact your previous DDS for x-rays? Yes ____ No ___ Previous DDS (Optional) _____

Do you require antibiotics before dental treatment? _____ If so, what/why? _____
How many times a day do you brush? _____ Floss? _____ Do your gums ever bleed? _____
Do you smoke? Yes _____ No _____ Packs/day _____ Are you nervous about dental treatment? _____

Are you now experiencing dental pain? _____ If so, are your teeth sensitive to: Cold? ____ Hot? ____ Sweets? _____

How were you referred to this office? _____

Medical History

PLEASE CIRCLE ONE

Please name your Primary Physician & Telephone #: _____

Have you been hospitalized in the last 5 years? …… YES NO

If so, for what? _____

Please list your medications: _____

_____

Please list any **medications** you are **allergic** to: _____

Please list **anything else** you may be **allergic** to: (For example, latex) _____

_____

Have you been diagnosed with cancer or tumor? …… YES NO

Have you ever had excessive bleeding that required treatment? …… YES NO

Do you require antibiotics before dental treatment? (If YES, please discuss) …… YES NO

Women: Are you pregnant or suspect your are pregnant? (for x-ray purposes) …… YES NO

Are you currently taking Birth Control pills? …… YES NO

Please circle any of the following medical conditions you may have at present:

Aids	Cholesterol Issues	Heart Failure	Nervousness
Alcohol Addiction	Cold Sore	Heart Murmur	Pain in Jaw Joint (TMJ)
Allergies or Hives	Congenital Heart Lesions	Heart Pacemaker	Rheumatic Fever
Anemia	Cough	Heart Surgery	Scarlet Fever
Angina (Chest pain)	Diabetes	Hemophilia	Sexually Transmitted Disease
Arthritis	Drug Addiction	Hepatitis / Jaundice	Sinus Trouble
Artificial Heart Valve	Emphysema	High Blood Pressure	Stroke
Artificial Joint	Epilepsy/ Seizures	HIV	Thyroid Problems
Asthma	Fainting or Dizzy spells	Kidney trouble	Tuberculosis (TB)
Blood Transfusion (recent)	Genital Herpes	Leukemia	Ulcers
Bruise Easily	Glaucoma	Liver Disease	Weight Gain/Loss
Cancer/Tumor	Hay Fever	Mitral Valve Prolapse	Any other important information?
Chemotherapy	Heart Disease / Attack		_____

****

Personal Guarantee

The undersigned does hereby personally guarantee, collectively and individually the full and timely payment to Lancaster Dental Associates, P.C. of all indebtedness heretofore or hereafter incurred for services rendered on behalf of the undersigned. This includes any and all collection fees that may be incurred. This guarantee may be revoked by written notice and any revocation does not revoke the obligation of the guarantor to provide full, prompt payment of indebtedness already incurred prior to revocation. The undersigned does hereby state that to the best of their knowledge the above information is true and correct. Any changes in the medical history will be disclosed at the next appointment. I understand that all photographs, radiographs and treatment records are the property of Lancaster Dental Associates, PC.

DATE: _____ Signature Patient, Parent, or Guardian_____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help!

OFFICE USE ONLY- Medical History Update/Medication List

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____