LAKE FOREST
· DENTAL ARTS ·

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Patient Information

Name		Birth Date	Single	Married	Widowed	Divorced
Home Phone	Home Address					Zip
Cell Phone	e-mail Address					
Business Phone	Business Address					
Preferred mode of contact						
Occupation		Employer				
Social Security Number		Who is responsible for this account?				
Parent's Names (If patient is a minor)						
Spouse's Name		Daytime Phone Number				
Person to contact in an emergency		Relationship		Phone Number(s)		
Other family members who come to this office						
Whom may we thank for referring you here?						

Dental Insurance *Please Present Insurance Card(s) to*

Primary Dental Insurance Company _____ Insured Employer _____

Insured Name _____ Insured Birth Date _____ Insured Social Security Number _____

Policy Number _____ Insured ID Number _____

Secondary Dental Insurance Company _____ Insured Employer _____

Insured Name _____ Insured Birth Date _____ Insured Social Security Number _____

Policy Number _____ Insured ID Number _____

Medical Information

Name and Phone Number of Personal Physician:

Name, Type, and Phone Number of Other Doctors currently seeing:
Are you seeing a Doctor for a medical condition? If yes, please explain.

List any illness or surgery within the last 5 years:

***Please Note*: Medications, Dietary Supplements , Vitamins, and Herbal Regimens can sometimes have effects on Dental Procedures.**

Please List any you are currently taking. (If you have a list with you, we will gladly make a copy.)

Have You Ever Had an Allergic or Undesirable Reaction To:

YES	NO		YES	NO	
❑	❑	Local Anesthetics (Novocaine, etc?)	❑	❑	Penicillin or Other Drugs? Please list
❑	❑	Oral Surgery or Tooth Extractions?	❑	❑	Acrylic, Latex, Jewelry, or Metals?

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Do You Have OR Have You Ever Had:

YES	NO		YES	NO		YES	NO	
❑	❑	Rheumatic Fever	❑	❑	Hay Fever or Allergies	❑	❑	Artificial Joint Replacement
❑	❑	Heart Trouble or Murmur	❑	❑	Asthma or Other Breathing Problems	❑	❑	Diarrhea Longer than 30 Days
❑	❑	Mitral Valve Prolapse	❑	❑	Sinusitis	❑	❑	Recent Unexplained Weight Loss
❑	❑	Heart Surgery	❑	❑	Tuberculosis or Other Lung Disease	❑	❑	White Spots/Sores in Mouth
❑	❑	High or Low Blood Pressure	❑	❑	Diabetes	❑	❑	Lumps in Neck, Groin, Armpits
❑	❑	Chest Pains	❑	❑	Kidney or Urinary Problems	❑	❑	Fever over 99 deg., longer than 30 days
❑	❑	Swelling of Feet or Ankles	❑	❑	Radiation Treatment or Chemo	❑	❑	Are You Pregnant? Due Date _____
❑	❑	Stomach or Digestive Trouble	❑	❑	Cancer or Tumor	❑	❑	Frequent Headaches
❑	❑	Anemia or Bleeding Disorder	❑	❑	Convulsions, Seizures or Fainting	❑	❑	Drug Addictions
❑	❑	Jaundice or Liver Problems	❑	❑	Arthritis	❑	❑	Tested Positive for HIV
❑	❑	Hepatitis: A B Delta Unknown	❑	❑	Hormonal Disturbances or Treatment	❑	❑	Other? Please Specify_____
❑	❑	Sexually Transmitted Diseases	❑	❑	Hearing Difficulties			

Dental History

How long since your last dental visit?_____ What was done then? _____

YES	NO	
❑	❑	Are you having any discomfort at this time? If so, explain_____
		Are your teeth sensitive to any of the following? ❑ Heat ❑ Cold ❑ Sweets ❑ Pressure ❑ Pain when Biting ❑ Spontaneous Aching
❑	❑	Have you ever had your teeth straightened (Orthodontics)?
❑	❑	Have you ever had a gum infection?
❑	❑	Do your gums bleed when you brush?
❑	❑	Do you have an unpleasant taste in your mouth?
❑	❑	Do you smoke or chew tobacco?
❑	❑	Do you grind or clench your teeth? If yes, when _____
❑	❑	Have you ever been treated for problems with your bite?
❑	❑	Have you been treated for TMJ or jaw joint problems?
❑	❑	Have you had previous bad experiences with dentistry?
❑	❑	Would you like to know what options are available to you to improve your smile?

Consent:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any diagnostic aid deemed appropriate by doctor to make a thorough diagnosis of needs.
2. I also consent to the performing of the dental care procedures agreed to be necessary or advisable, including the use of local anesthesia as indicated. I understand that using anesthetic agents embodies a certain risk. Furthermore, i authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all responsibility for payment of dental services provided is mine and that payment is due at the time services are rendered unless prior financial arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 1/2% finance charge (18% APR) maybe added to my account.

X

Patient's (or Parent's) Signature Date