

Patient Information

Date: / / Social Security: _____ Birth date: / /

Name: _____ Cell Phone: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Sex: M F Status: Married Child Single Separated Divorced Widowed

Employer: _____ E-mail: _____

Business Address: _____ Business Phone: _____

Occupation: _____

Whom may we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone: _____

Dental Insurance-1st coverage

Name of Dental Insurance Company: _____

Dental Insurance-2nd coverage

Name of Dental Insurance Company: _____

Assignment and Release

I hereby authorize payment directly to Lovin Dental all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependants. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____

Medications

Pharmacy: _____ Pharmacy Phone # _____

Medications	Dosage	Reason
1.		
2.		
3.		
4.		
5.		

Dental History

Former Dentist _____ Date of last X-Rays _____

City, State _____ How often do you floss? _____

Date of last Dental visit _____ How often do you Brush? _____

Patient Information

Medical History

Physicians Name: _____ Phone# _____ Date of last visit: _____

	Yes	No		Yes	No
1. Are you currently under medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	7. Have you had any allergic reactions to the: Following		
2. Have you ever had any serious illnesses or operations?	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you pre-medicate with antibiotics prior to dental procedures?	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use alcohol or other recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates (Sleeping Pills)	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a Substance Addiction?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
			Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
			Other	<input type="checkbox"/>	<input type="checkbox"/>
			8. (Women Only) Are you:		
			Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
			Nursing?	<input type="checkbox"/>	<input type="checkbox"/>
			Taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

Please check all that apply:

<input type="checkbox"/> Aids	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fainting or Dizziness	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Headaches	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Hepatitis-Type	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Herpes	<input type="checkbox"/> Seizures
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV Positive/Aids	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Swelling of Feet/Ankles
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Swollen Neck Gland
<input type="checkbox"/> Condenital Heart Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Cough – Persistent or bloody	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Tumor or growth on head/neck
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Ulcer
		<input type="checkbox"/> Venereal Disease

I understand a broken appointment charge may be applied to my account for missed appointments or appointments canceled without 24 hours notice.

I certify that I have read and understand the above statement. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction and I will not hold Lovin Dental or any of their staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Name: _____

Signature of Patient/Guardian _____

Date _____

Dr. _____

Date _____