Please answer the following general health questions.

1. Are you in good health? .... yes no
2. Date of your last physical exam ____________
3. Are you now under the care of a physician? .... yes no
   Physician's name ____________ Phone #____________
4. Have you been hospitalized or had a serious illness within the past 5 years? .... yes no
5. Are you now taking any medications? .... yes no
   If yes, please list those medications ____________
6. Do you take any herbal medications or vitamins? .... yes no
   If yes, please list those medications ____________
7. Are you allergic or have you reacted adversely to any of the following medications? (Please circle if yes)

Aspirin	Vicodin	Novocaine or Lidocaine	Penicillin
Tylenol	Demerol	Valium	Tetracycline
Local Anesthetic	Percodan	Sleeping Pills	Erythromycin
Nitrous Oxide	Darvon	Codeine	Sulpha

8. Please list any other medication or substance to which you are allergic ____________
9. Have you ever had: (Please circle if yes)

Anemia	Convulsions	Heart Trouble	Rheumatic Fever
Angina Pectoris	Diabetes	Hepatitis or liver disease	Stroke
Arthritis	Epilepsy	High Blood Pressure	Tuberculosis
Artificial joint	Glaucoma	Jaundice	Tumor or growth
Asthma	Heart Attack	Kidney Disease	Ulcers
Bleeding problems	Heart Murmur	Latex Allergies	Venereal Disease
Blood transfusion	Heart Pacemaker	Positive test for AIDS virus	Other____________
Chemotherapy			

10. Do you get up often at night to urinate? .... yes no
11. Are you thirsty much of the time? .... yes no
12. Has anyone in your family had diabetes? .... yes no
13. Do you consider yourself a nervous person? .... yes no
14. Do you smoke? .... yes no
    If yes, how much?____________ Do you use spit tobacco? .... yes no
15. Do you have any disease, condition or problem not listed above that you think we should know about? .... yes no
16. Are you on a special diet? .... yes no

For Women only: Are you pregnant? .... yes no
If yes, what month? ____________ Due date: ____________
Are you practicing birth control? .... yes no

CONSENT: The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)____________ and further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. If necessary, payment plans may be arranged. To the best of my knowledge, I have provided information which is true and correct. If I ever have any change in my health, or if my medications change, I will inform the Doctor at the next appointment without fail.

Signature ____________ Date ____________

Signature ____________ Date ____________

NOTES

Patient Health Record

We welcome you to our office!

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions.

LAKESIDE
FAMILY DENTISTRY
Member ADA, ODA, AGD

If this appointment is for you start here

Date ____
Name ____
Address ____
____
Home Phone # ____
Cell Phone # ____
Best # to Call ____
Email Address ____
____
Birthdate ____
❑ Married ❑Single ❑Divorced ❑Widowed

Primary Dental Insurance

Insurance Co. Name: ____
Insurance Co. Address: ____
____
Insurance Co. Phone #: ____
Insurance ID #: ____
Insurance Group # ____
Insured's Name: ____ Relation: ____
Insured's Birthday: __/__/__ Insured's SS#: ____
Insured's Employer: ____

Secondary Dental Insurance

Insurance Co. Name: ____
Insurance Co. Address: ____
____
Insurance Co. Phone #: ____
Insurance ID #: ____
Insurance Group #: ____
Insured's Name: ____ Relation: ____
Insured's Birthday: __/__/__ Insured's SS#: ____
Insured's Employer: ____

If this appointment is for your child start here

Date ____
Name ____
Address ____
____
Home Phone # ____
Birthdate ____ Age ____
Grade ____
School ____
If your child's address is different from yours, please fill in the top box also.

Account Information

Person Responsible for Account ____
Your Occupation ____
Your Employer ____
Your Employer Phone # ____
Your Driver's License # ____
Bank ____
Your Spouse ____
Spouse's Employer ____
Spouse's Employer Phone # ____

Getting to know you

What are your hobbies and interests? ____
____
Where were you raised? ____
Number of children? ____
Are any of your relatives a patient of our office? ____
Referred to us by ____
Person to contact for emergency ____
Phone ____
How do you wish to be addressed by our staff? ____

Please fill out the Medical History on the other side.

Dental History

Reason for today's visit ____ Date last Dental visit ____ What was done then? ____
How often do you brush your teeth? ____ Floss? ____ What texture brush do you use? ____
Previous Dentist? ____ Reason for leaving dentist? ____

Do any of the following conditions apply to you? (circle yes or no)

Bleeding gums?	yes	no
Food impaction?	yes	no
Swelling or lump in mouth?	yes	no
Clenching or grinding teeth?	yes	no
Unpleasant taste?	yes	no
Tired Jaws?	yes	no
Gag easily?	yes	no
Complications from extractions?	yes	no
Gum Treatments?	yes	no
Teeth straightened?	yes	no
Sounds in ears when chewing?	yes	no
Loose teeth?	yes	no
Avoid Brushing any area of your mouth?	yes	no
What area? ____		
I would like my teeth whiter	yes	no
I prefer tooth colored fillings	yes	no
Use Fluoride supplements?	yes	no

Do your teeth hurt when in contact with:

Hot foods or liquids?	yes	no
Cold food or liquids?	yes	no
Sweet foods or liquids?	yes	no
Bite or pressure sensitivity?	yes	no
Are you satisfied with the appearance of your teeth?	yes	no
Any serious problems with dental treatment?	yes	no
Do you have any mouth pain?	yes	no