Patient Name: ____________________________ Date of Birth ___________

Social Security Number: ____________________

So that we can better assist you with your dental concerns, please list in order of importance what is essential to you.

Please mark 1—3, with 1 being most important item.

___Health preservation/keeping your teeth for life, eliminate disease
___Comfort and function/eating what you want to eat
___Esthetics/how your smile looks

If you have had dental treatment recommended in the past and did not proceed, what factors prevented you from scheduling? (Here or elsewhere)

___Cost
___Fear of pain
___No time
___No insurance
___Didn't hurt/ Didn't think I needed treatment
___Other (please explain)_________________________________

HEALTH HISTORY

Check if you have or had any of the following:

___AIDS
___Anemia
___Arthritis
___Artificial Heart Valve
___Artifical Joints
___Asthma
___Back Problems
___Cancer, Tumor, Malignancy
___Chemical Dependency
___Chemotherapy
___Circulatory Problems
___Cortisone Treatments
___Cough up blood
___Congenital Heart Disorder
___Cough, Persistant

___Diabetes
___Epilepsy, Seizures
___Fainting, Dizziness
___Glaucoma
___Headaches
___Heart Attack
___Heart Murmur
___Hepatitis, Type ____
___Herpes
___High Blood Pressure
___HIB Positive
___Hospitalization
___Immune Disorder
___Jaundice
___Kidney Disease
___Liver Disease

___Major Surgery, Type _________________
___Mitral Valve Prolapse
___Nervous Problems
___Pacemaker
___Pain in Jaw Joint
___Prolonged Bleeding Disorder
___Psychiatric Care
___Radiation Treatment
___Respiratory Disease
___Rheumatic Fever
___Scarlet Fever
___Shortness of breath
___Sinus Trouble
___Skin Rash
___Stroke

___Swelling of Feet or Ankles
___Taking Fen-Phen or Redux
___Thyroid Problems
___Tobacco Habit, Type ____________How much __________
___Tonsilitis, Lung Disease
___Tuberculosis
___Ulcer
___Venereal Disease
___Are you Pregnant? Due Date ______

Medications
List medications you are currently taking:
(Include oral contraceptives and alternative medicines)
____
____
Pharmacy Name: ____________________________
Phone: ______________________________

Allergies
___Aspirin
___Barbiturates
___Codeine
___Latex
___Local Anesthetic
___Penicillin
___Sulfa
___Other _____________

The above information is accurate and complete to the best of my knowledge. I will not hold the dentist or any member of Lakeview Dental responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____ Date ____________________________________

Authorization
I authorize my insurance company to pay to Lakeview Dental all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that Lakeview Dental cannot render services on the assumption that any of the charges will be paid by an insurance company. **I understand that I am financially responsible for all charges whether paid by my insurance or not.**

Signature ____ Date _______________________________

Payment is due in full at time of treatment unless prior arrangements have been made

PATIENT REGISTRATION

First Name : ____________________ Last Name: ____________________

Patient is ☐ Policy Holder
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: ____________________ Last Name: ____________________
Address: ____________________ Address 2: ____________________
City, State, Zip: ____________________
Home Phone: ____________ Work Phone: ____________ Cellular: ____________
Birth Date: ____________ Soc. Sec. ____________
Drivers License Number: ____________________

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ____________________ Address 2: ____________________
City: ____________________ State/Zip ____________________
Home Phone: ____________ Work Phone: ____________ Cellular: ____________
Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated
Birth Date: ____________ Age: ________ Social Security Number: ____________
E-Mail ____________________ ☐ I would like to receive correspondence via e-mail

———————-Section 2 ————————————————————————-Section 3 ———————————

Employment Status: ○ Full Time ○ Part Time ○ Retired
Student Status: ○ Full Time ○ Part Time
Medicaid ID: ____________ Pref. Dentist: ____________
Employer ID: ____________ Pref. Pharmacy: ____________
Carrier ID: ____________ Pref. Hygienist: ____________

Emergency Contact: ____________
Relation: ____________
Phone: ____________

Primary Insurance Information

Name of Insured: ____________________ Relationship to Patient ○ Self ○ Spouse ○ Child ○ Other
Insured Social Security No. ____________ Insured Birth Date: ____________
Employer: ____________________
Address: ____________________
Address 2: ____________________
City/State/Zip: ____________________
Rem. Benefits: ________.00 Rem. Deduct: ________.oo

Insurance Company: ____________________
Address: ____________________
Address 2: ____________________
City/State/Zip: ____________________

Secondary Insurance Information

Name of Insured: ____________________ Relationship to Patient Self Spouse Child Other
Insured Social Security No. ____________ Insured Birth Date: ____________
Employer: ____________________
Address: ____________________
Address 2: ____________________
City/State/Zip: ____________________
Rem. Benefits: ________.00 Rem. Deduct: ________.oo

Insurance Company: ____________________
Address: ____________________
Address 2: ____________________
City/State/Zip: ____________________