WELCOME

In order to ensure your maximum oral health and allow us to prescribe the proper medications when necessary, it is very important that we know all medical and dental information about you. Please check every box on the front and back of this form, even if the answer is N/A [not applicable]. This information will be kept in the strictest confidence.

You also should know that changes in other parts of your body may affect the oral cavity and what dental treatment can be done, even if they don't seem connected. (Cardiac [heart] problems, artificial joints, and diabetes are just some examples.) Will you please inform either Dr. Lawrenz or a staff member at the beginning of each new office visit if your medical or dental conditions have changed since we last say you? Yes ___ No ___ Thank you.

Patient Information

Date _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ M __ F __ Age _____

Patient's e-mail address _____

Single ____ Married ____ Widowed ____ Separated ____ Divorced ____

Patient's SS # _____ - ____ - _____

If Patient is a minor, parent's or guardian's name _____

_____

Patient's Occupation _____

Employer _____

Spouse's Name _____

Spouse's Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Responsible Party _____

SS # or ID # _____ Birthdate _____

Relationship to patient _____

Responsible Party's Employer _____

Insurance Company _____

Group # _____

Is patient covered by additional insurance? Yes ___ No ___

Subscriber's Name _____

SS # or ID # _____Birthdate _____

Employer _____

Insurance Company _____ Group # _____

Phone Numbers

Home Phone _____

Cell Phone _____

Work Phone _____

Spouse's Cell Phone _____

Spouse's Work Phone _____

Family Physician's Name _____

Physicians's Phone _____

IN CASE OF EMERGENCY, CONTACT (*Spedify someone who does not live in your household, please.)*

Name _____

Relationship _____

Daytime Phone _____

Cell Phone _____

Assignment and Release

I certify that I (or my dependent) have insurance coverage as indicated and assign directly to this office 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. I authorize the doctor to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship to minor 9if applicable) _____ *Date* _____

Electronic Notification

Would you like e-notification for recalls? Yes ___ No ____

Would you like e-statements in place of paper? Yes ____ No ____

Dental History

Reason for today's visit _____

_____

Former dentist _____

Date of last dental visit _____

Date of last dental x-rays _____

Mark "Yes" or "No" to indicate if you presently have or previously had any of the following:

Bad breath	Y__ N __
Bite lips or cheeks often	Y __ N __
Bleeding gums	Y __ N __
Blisters - lips or mouth	Y __ N __
Chew mostly on one side of mouth	Y __ N __
Dry mouth	Y __ N __
Food collects between teeth	Y __ N __
Brux, clench or grind teeth	Y __ N __
Gums swollen, tender or bleed	Y __ N __
Jaw pain or tiredness	Y __ N __
Mouth breathing	Y __ N __
Orthodontic treatment	Y __ N __
Pain around ear(s)	Y __ N __
Periodontal/gum treatment	Y __ N __
Tooth sensitivity to cold	Y __ N __
Tooth sensitivity to hot	Y __ N __

Have you or do you experience(d) -

Clicking or popping of jaw joint	Y __ N __
Pain? (Joint, ear, side of face)	Y __ N __
Difficulty in opening or closing	Y __ N __

How often do you floss? _____

How often do you brush? _____

Do you require antibiotics prior to dental treatment? Y __ N __

Are you currently in pain? Y __ N __

Have you ever had a serious/difficult problem associated with any dental work? Y __ N __

Do you feel nervous about having dental treatment? Y __ N __

Do you like your smile? Y __ N __

Is there anything else about having dental treatment that you'd like us to know? Y __ N __

_____

_____

_____

_____

_____

_____

Medical History

Your current physical health is
Good ___ Fair ___ Poor ___

Are you currently under the care of a physician? Y __ N __

Please explain: _____

_____

Are you taking any prescription/over the counter drugs? Y __ N __
Please list:

_____

_____

_____

_____

_____

Do you smoke or use tobacco in any other form? Y __ N __

Do you now have or have you ever had any of the following diseases or medical problems?

Abnormal bleeding	Y __ N __
Alcohol / drug abuse	Y __ N __
Alzheimer's disease	Y __ N __
Anemia	Y __ N __
Arthritis of any type	Y __ N __
Artificial bones, joints, or valves	Y __ N __
Asthma	Y __ N __
Blood transfusion(s)	Y __ N __
Bruise easily	Y __ N __
Cancer/ chemotherapy	Y __ N __
Colitis	Y __ N __
Diabetes	Y __ N __
Difficulty breathing	Y __ N __
Emphysema	Y __ N __
Epilepsy	Y __ N __
Fainting Spells / Syncope	Y __ N __
Frequent Headaches	Y __ N __
Glaucoma	Y __ N __
Hay fever / allergies	Y __ N __
Heart problems	Y __ N __
Heart murmur	Y __ N __
Hemophilia	Y __ N __
Hepatitis	Y __ N __
Herpes / fever blisters	Y __ N __
High blood pressure	Y __ N __
HIV / AIDS	Y __ N __
Hospitalized for any reason	Y __ N __
Joint replacement	Y __ N __
Kidney problems	Y __ N __
Liver disease	Y __ N __
Low blood pressure	Y __ N __
Mitral valve prolapse	Y __ N __
Nervousness / anxiety	Y __ N __
Osteoporosis	Y __ N __
Pacemaker	Y __ N __
Psychiatric / psychological care	Y __ N __
Radiation therapy	Y __ N __
Rheumatic / scarlet fever	Y __ N __
Seizures	Y __ N __
Sinus problems	Y __ N __
Stroke / TIA's	Y __ N __

Medical History (cont'd)

Thyroid problems	Y __ N __
Tuberculosis / TB	Y __ N __
Tumors or growths	Y __ N __
Ulcers	Y __ N __
Venereal disease	Y __ N __

Do you have or have you had any disease, condition, or medical problem not listed? Y __ N __

Are you allergic to any of the following?

Aspirin	Y __ N __
Codeine	Y __ N __
Dental anesthetics	Y __ N __
Latex	Y __ N __
Metals	Y __ N __
Penicillin	Y __ N __
Tetracycline	Y __ N __

Please list any other drugs / materials that you are allergic to:

_____

_____

_____

_____

_____

Do you snore or have you been told you snore? Y __ N __
Do you wake up during the night? Y __ N __
Do you experience excessive daytime sleepiness? Y __ N __
Have you ever had a sleep study? Y __ N __
Do you have high blood pressure? Y __ N __

For women only:

Are you taking birth control pills?	Y __ N __
Are you pregnant?	Y __ N __
Due date	_____
Are you nursing?	Y __ N __

Certification: **I certify that the answers given are correct to the best of my knowledge.**

Signature _____

Date _____