LAKE GROVE DENTAL

PATIENT INFORMATION

Name _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other _____
Full Legal Name

Preferred Name _____ E-mail _____

Gender: _____ Preferred Pronouns: _____ Birthdate _____ SSN# _____

Address _____ Occupation _____

City _____ ST _____ Zip _____ Mobile # _____

Employer _____ Home or Other Phone # _____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated [ ] Other _____

Emergency Contact Name _____ Relationship _____ Phone# _____

RESPONSIBLE PARTY (Only complete if different than the patient above) Relationship to patient: _____

Name _____ Address _____
First MI Last

Email _____ City _____ ST _____ Zip _____

Mobile Phone# _____ Wk# _____ Birthdate _____ SSN# _____

Responsible Party Signature: _____

DENTAL BENEFITS INFORMATION: As a courtesy to our patients, we bill your dental benefits carriers directly. It is your responsibility to understand your coverage, maximum, and exclusions. We will go out of our way to help you know what you have at your request. Your insurance is a contract between you and your insurance company. Benefits are frequently based on your insurance's contract and may not reflect on your best treatment options.

STUDENTS WITH BENEFITS: Status: [ ] Full-time [ ] Part-time School Name & City _____

DENTAL BENEFITS (A photocopy of your card may suffice)

Subscriber's Name _____ Relationship to patient _____

Birthdate _____ Policy ID# _____ Employer _____

Insurance Co. Name _____ Ins. Co. Address _____

City _____ ST _____ Zip _____ Group # _____ Eff. Date _____

SECONDARY DENTAL BENEFITS? [ ] Yes [ ] No If yes, please complete the following:

Subscriber's Name _____ Relationship to patient _____

Birthdate _____ Policy ID# _____ Employer _____

Insurance Co. Name _____ Ins. Co. Address _____

City _____ ST _____ Zip _____ Group# _____ Eff. Date _____

Caring for More Than Just Your Teeth

Good oral health benefits your whole-health

MEDICAL INFORMATION

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Cardiovascular

- □ A-Fib
- □ Heart Valve Replaced
- □ Coronary Artery Disease
- □ Chest Pain or Angina
- □ Congestive Heart Failure
- □ Heart Attack
- □ Heart Murmur
- □ Heart Stent Installed
- □ High Blood Pressure
- □ High Cholesterol
- □ Irregular Heartbeat
- □ Low Blood Pressure
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Tachycardia

Endocrine

- □ Diabetes
- □ Pre-Diabetic
- □ Gout
- □ Hormonal Change
- □ Thyroid problems

Eyes, Ears, Nose and Throat

- □ Change in Hearing
- □ Change in Vision
- □ Ear Pain
- □ Glaucoma
- □ Hay Fever
- □ Nasal Obstruction
- □ Nose Bleeding
- □ Sinus Problems
- □ Tonsillectomy
- □ Tinnitus (Ringing)

Gastrointestinal

- □ Acid Reflux
- □ GERD
- □ Soft or Special Diet
- □ Ulcers

Genitourinary

- □ Frequent Urination
- □ Kidney disease
- □ Nocturia
- □ Dialysis

General

- □ Cancer, if yes describe _____
- □ In Cancer Treatment Now Describe: _____
- □ General Weakness
- □ Fatigue/Tired
- □ Headaches
- □ HIV/STD List: _____
- □ Knee/hip replacement
- □ Liver Disease/Problems
- □ Recent Trauma or Injury
- □ Rheumatic Fever
- □ Radiation Treatment
- □ Unexplained Weight Change
- □ Swollen ankles
- □ Organ Transplant – List: _____

Hematological

- □ Bleeding problems
- □ Hepatitis Type _____
- □ Last A1C score _____

Oral

- □ Bleeding Gums
- □ Dry Mouth
- □ Sjogren's Syndrome
- □ Jaw Problems (TMJ)
- □ Jaw Clicking
- □ Jaw Pain
- □ Difficulty Swallowing
- □ Difficulty Chewing
- □ Has Had Orthodontics
- □ Periodontal Disease
- □ Teeth Clenching/Grindin
- □ Tooth Pain
- □ Wisdom Tooth Extraction
- □ Removable Teeth
- □ Wears a nightguard
- □ Wear Ortho Retainer(s)

Musculoskeletal

- □ Artificial Joint
- □ Arthritis
- □ Back Pain
- □ Fibromyalgia
- □ Joint Pain
- □ Osteopenia
- □ Osteoporosis
- □ Spinal Surgery

Neurological

- □ Alzheimer's Disease
- □ Dizziness
- □ Epilepsy
- □ Fainting
- □ Memory Loss
- □ Multiple Sclerosis (MS)
- □ Muscle Weakness
- □ Seizures
- □ Stroke Date _____
- □ Tingling/Numbness
- □ Trigeminal Neuralgia
- □ Tremor

Psychiatric

- □ ADD/ADHD
- □ Anxiety
- □ Chemical Dependency
- □ Depression
- □ Autism
- □ Eating Disorders
- □ Excessive Stress
- □ Memory Problems

Respiratory

- □ Asthma
- □ Bronchitis
- □ Breathing Problems
- □ Chest Pressure
- □ COPD
- □ Congestion
- □ Dyspnea (shortness of breath)
- □ Emphysema
- □ Orthopnea (Can't Lay Flat)
- □ Pneumonia
- □ Pulmonary Embolism
- □ Tuberculosis

Sleep

- □ Daytime Sleepiness
- □ Morning headaches
- □ Others say you snore
- □ Sleep Study Done - Results:
  - o Mild
  - o Mod
  - o Severe
  - o No Apnea
- □ Obstructive Sleep Apnea
- □ Do you use a CPAP? If so, how often? _____
- □ Wear oral device for sleep apnea?

Habits

- □ Alcohol
  - o Less than 1/day
  - o More than 1/day
- □ Smoke or Chew currently Qty: _____
- □ Former Smoker, when quit Year: _____
- □ Vape currently
- □ Recreational Drugs
- □ Special Diet

ANY Other Not Listed:

_____

_____

_____

This information will not be shared without the express authorization of the patient. Updates are required every two years or when there are significant health changes.

In a few words, how would you describe your overall health? _____

Has there been a change in your health or the medications you take in the last two years? Please describe: _____

_____

Have you gone to the hospital or had a serious illness in the last two years? Why/what? _____

Are you being treated by a physician now? Yes ____ No ____ If yes, for what? _____

When was your last physical? _____ Physician's Name/City _____

Your current weight? _____ Your height? _____ Women: Are you or could you be pregnant? Due Date _____

Do you have any pain in your body now? Yes____ No____ If yes, describe _____

Do you currently need to be premedicated for dental treatment? Yes ___ No ___ If so, for what? _____

Emergency contact: Name _____ Relationship _____ Phone _____

Allergies: Are you allergic to or had a reaction to:

- ☐ Local anesthetic
- ☐ Foods– Describe _____
- ☐ Penicillin
- ☐ Other Antibiotics _____
- ☐ Sulfa drugs
- ☐ Metal(s)- Describe _____
- ☐ Tranquilizers/Sedatives
- ☐ Aspirin _____
- ☐ Codeine or other narcotics
- ☐ Latex
- ☐ Other – Please list any

_____

_____

_____

Have you ever experienced anaphylaxis? Yes___ No___ If so, what triggered the episode? _____

Medication Information

Are you currently, or have you taken in the past, medications for bone density? Yes ____ No ____

Please list all medications and supplements (vitamins) you are currently taking or provide a printed list: _____

_____

_____

_____

_____

_____

I certify that I have read and understand the entire medical and dental history forms. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist and his staff of any changes in my health and/or medications. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of these forms.

Signature of Patient (or Guardian) _____ Date _____

Signature of Healthcare Provider _____ Date _____