LB Dental

Welcome

The benefits of a healthy beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve.

PLEASE complete this form so that we can provide the best care possible for you.

About you:

Today's date_____

Name_____ I like to be called: _____

Home Address: _____

City_____, State_____ Zip_____

Social security number _____--_____--_____ Gender M ☐ F ☐ Date of Birth: _____

Occupation_____Employer:_____Full Time: ____ Part Time: _____

Employer Address: _____ or Student: _____

How did you find out about us? Patient Referral Name: _____
Internet: Website Facebook Email Other: _____
Other: _____

Marital status: Single Married Divorced Widowed Spouse name: _____

Special interests or hobbies: _____

Phone Info

Home phone: _____ Work phone: _____

Cell phone: _____ E-mail address: _____

Text Message: YES ___ or NO____ *Cell Phone carrier if you would like a text message._____

When is the best time to call you? _____and Where? _____

In case of emergency, is there someone we can call? Relationship to contact _____

Name: _____ Phone Number: _____

Please Sign_____ Date _____

(If patient is under the age of 18 parent or guardian signature required)

LB Dental

Medical History

Physician: _____ Phone number: _____ last visit: _____

Current health: Excellent Good Fair Poor

Current Weight: _____ Height: _____

Do you smoke or use tobacco? Yes ☐ No ☐ If YES, How much per day? _____

Are currently taking prescription medications Yes ☐ No ☐ If YES, Please list below …….

Name of medication	**Purpose**

Have you had any serious medical problems within the last **5 years**? Yes ☐ No ☐ if YES, please Explain: _____

For women : Are you pregnant? Yes ☐ No ☐ If Yes, # of Weeks? _____ Are you nursing? _____

Do you need to be **Pre-Medicated** before dental procedure Yes ☐ No ☐ Don't know ☐

Have you ever taken **Bisphosphonates** for **Osteoporosis**: Yes ☐ No ☐ If yes…? Orally ☐ IV-Intravenous ☐

Have you ever had or been treated for any of the following diseases or medical problems?

Y N Frequent Headaches	Y N Congenital Heart	Y N Difficulty Breathing
Y N Heart attack	Y N Heart murmur	Y N Anemia
Y N Angina Pectoris	Y N Heart Transplant	Y N Thyroid Problems
Y N Stroke	Y N Rheumatic Fever	Y N Yellow Jaundice
Y N Hepatitis A/ B/C	Y N High Blood Pressure	Y N Diabetes
Y N Liver Disease	Y N Low Blood Pressure	Y N Tuberculosis
Y N Fainting Spell	Y N Epilepsy	Y N Seizure
Y N Fever Blister/Cold Sore	Y N Abnormal bleeding	Y N Kidney problems
Y N AIDS/HIV	Y N Ulcers	Y N Sinus Problems
Y N Pneumocystis	Y N Blood Transfusion	Y N Asthma
Y N Emphysema	Y N Alcohol Abuse	Y N Psychiatric problems
Y N Artificial Joints	Y N Drug abuse	Y N Venereal disease
Y N Lock Jaw	Y N Heart Pacemaker	Y N Alzheimer/Dementia Disease
Y N Cancer	Y N Radiation	Y N Chemotherapy

Type: _____ Date of Diagnosis: _____ Date of Therapy: _____

Are you allergic to: Y N Penicillin Y N Erythromycin Y N Tetracycline Y N Codeine
Y N Latex Y N Metals Y N Dental anesthetic Y N Aspirin

Are you allergic to any other medication or anything else? Yes No if yes please explain: _____

_____

Please Sign_____ Date_____

(If patient is under the age of 18 parent or guardian signature required)

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Dental History

Why have you come to dentist today? _____

How would you describe condition of your teeth and gums? Good Fair Poor

Are you currently in pain or discomfort with your teeth or gums? Yes No if yes please explain:

_____

The date of your last dental visit: _____ Previous dentist's name: _____

If you could change anything about the appearance of your smile or teeth what would you like to do?

_____

_____

_____

How often do you brush your teeth? _____ Floss your teeth? _____

Do your gums bleed when you brush? Yes No Floss Yes No

Have you ever experienced pain in your jaw joint? Yes No

Do you grind/clench your teeth? Yes No

Do you have frequent headaches? Yes No

Have you been treated for TMJ symptoms? Yes No

Many patients consult us for a second opinion. Have you seen another dentist?

Yes No if yes please explain: _____

_____

What are your goals and desires regarding your dental health _____

_____

Please Sign _____ Date_____

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LB Dental

Oral Cancer Screening Waiver Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor of oral cancer. Tobacco and alcohol use are the other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patients profile is as follows:

Increased risk: patients ages 18-39
High risk: patients age 40 and older; tobacco users (any age, any type within 10 years)
Highest risk: patients age 40 and older with lifestyle risk factors (tobacco and/0r alcohol use); previous history of oral cancer.

We have recently incorporated ViziLite Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early Detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The ViziLite Plus e3xam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is $_____.

☐ **Yes.** I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name:_____

Signature:_____Date:_____

☐ **No.** I would prefer not to have the ViziLite Plus exam at this time.

Print name:_____

Signature:_____Date:_____

Insurance Info

Primary Dental Insurance_____ Effective date _____

Subscriber Name _____Soc Security #_____

Employer_____

Member ID:_____Group#:_____Policy#:_____

Relation to Patient: self spouse child other

Secondary Dental Insurance _____ Effective date _____

Subscriber Name _____SS #_____Employer_____

Member ID:_____Group#:_____Policy#:_____

Relation to Patient: self spouse child other

Primary Medical Insurance_____ Effective date _____

Subscriber Name _____Soc Security #_____

Employer_____

Member ID:_____Group#:_____Policy#:_____

Relation to Patient: self spouse child other

INSURANCE FILING

We file Insurance Claims as courtesy to our patients. We can only make ESTIMATES regarding your Insurance Benefits based on information provided by you and your Insurance Company. You, the patient, are ultimately responsible for the payment in full on your account.

Payment in full is expected at the time of service unless other arrangements were made.

All delinquent accounts are subject to reasonable service charges and/or legal interest rates.

Any account turned over to a collection agency forfeits any past special fees and/or discounts, which will be reversed at that time.

Signature of Responsible Party_____

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby authorize LB Dental and/or their trained staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize LB Dental and/or their trained staff to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release any medical/dental information which may be indicated to process insurance claim forms or receive proper treatment from other health specialists.

Signature _____Dr. Signature_____ Date_____

(If patient is under the age of 18 parent or guardian signature required)