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 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

Name: _____

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: NO ☐ Yes ☐ If yes…? Orally ☐ IV-Intravenous ☐

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

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 Cancer	Y N Radiation	Y N Chemotherapy

Type: _____

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_____

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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_____

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

LB Dental

Insurance Info

Primary Dental Insurance_____ Effective date _____

Subscriber Name _____Soc Security #_____

Employer_____

Group#/Policy#: _____ Relation to Patient self spouse child other

Secondary Dental Insurance _____ Effective date _____

Subscriber Name _____SS #_____Employer_____

Group#/Policy#: _____ Relation to Patient self spouse child other

INSURANCE FILING

We file Dental 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 maybe 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)