Lane Dental

Today's Date____/____/____

Patient Registration

Last Name ______________________ First Name ___________________ Mr. Ms. Dr.

Home Address ____

City _______________________________________ State _________ ZIP ___________________

Home Phone Number (_____)_______-________ Work Phone (_____)______-___________

Cell Phone (_____)_______-_______ Email Address ___________________________________

Social Security Number _____________________ Date of Birth ________/________/_______

Employer ____

Employer Address ___________________________________ Occupation _________________

Emergency Contact________________________ Phone Number (_____)________-_________

Whom May We Thank For Referring You? ____

Preferred Days or Times for Appointments? ____

Patient Signature____ Date ____________________

Please Turn Page Over

Insurance/ Account Information

Last Name of Insured _________________________ First Name _________________________

Home Address (if different from above) ____

City __________________________________ State ____________ ZIP ____________________

Subscriber's Social Security Number ____________ Date of Birth _____/______/_______

Relationship to Patient __________ Employer Sponsoring Insurance Plan _________________

Dental Insurance Company _____________________ Policy Number _____________________

Insurance Address ____

City _____________ State ______ ZIP _________ Insurance Phone (_____)______-_______

Patient Signature______________________________________ Date ____________________

Please Turn Page Over

Lane Dental

Health History

Physician Name ________________ Phone ________________ Today's Date ____________________

Date of Last Exam ___/____/____ Address of Physician

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Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. <u>All information you provide will be kept confidential</u>.

*****PLEASE ANSWER BY CIRCLING Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION.**

1. Are you in good health?..Y N
2. Has there been any change in your general health in the past year?..Y N
3. Are you currently under a physician's care?..Y N
   If so, what for?____

4. Have you had any serious illness, operations, or hospitalizations? ....Y N
   If so, describe and give approximate dates____

5. Have you ever had intravenous sedation or general anesthesia?..Y N
   Were there any adverse effects?..Y N
6. Do you generally tolerate dental treatment well?..Y N
7. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Heart disease that was detected at birth (congenital)?..Y N
   - B. Rheumatic fever or Rheumatic heart disease?..Y N
   - C. Cardiovascular disease (heart attack, high blood pressure, heart surgery, pacemaker, etc.?)..........................Y N
   - D. Lung Disease (asthma, emphysema, bronchitis, pneumonia, TB, shortness of breath, etc.)..........................Y N
   - E. Neurologic Disorders (migraines, seizures, epilepsy, fainting, dizziness, anxiety disorder, etc..)?..................Y N
   - F. Blood Disease (bleeding disorder, anemia, blood transfusion, bruise easily, etc..)?..Y N
   - G. Liver Disease (jaundice, hepatitis, cirrhosis)?..Y N
   - H. Kidney Disease?..Y N
   - I. Diabetes?..Y N
   - J. Thyroid Disease (hypothyroidism, tumor)?..Y N
   - K. Stomach ulcers or Intestinal problems?..Y N
   - L. Glaucoma?..Y N
   - M. Frequent or recurring mouth sores?..Y N
   - **N. Implants/artificial joints anywhere in your body (Heart valve, hip, knee,etc..)?..Y N**
   - O. Radiation/X-Ray treatment to the head and neck region?..Y N
   - P. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth?..Y N
   - Q. Sinus or nasal problems?
   - R. Any disease, drug or transplant operation that has depressed your immune system?
   - S. Recurrent infections of any kind?
8. **ARE YOU TAKING OR USING ANY MEDICATIONS?**
   PLEASE LIST ALL CURRENT MEDICATIONS HERE : ____
   ____
9. **Please List Any Medications You Have ALLERGIES to (please also include allergies to any OTC drugs, latex, novocaine, etc.)**
   ____
10. Do you smoke or use smokeless tobacco?
11. Are you, or have you been, in a drug or alcohol recovery program?..Y N
12. WOMEN:
    - A. Are you/ is there any chance you may be pregnant?..Y N
    - B. Are you taking birth control pills (these may be rendered ineffective by certain medications we use).......... Y N

Please Turn Page Over

I affirm that the medical information I have provided is done to the best of my knowledge and accurate. I will notify the presiding doctor of any changes in medical history.

Patient Signature_______________________________________ **Date** ______________________

Doctor Signature_______________________________________ **Date**_______________________