Lyme Road Dental, PLLC
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*Masters, in the Academy of General Dentistry*

*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. Please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.*

# *Patient Information* (*CONFIDENTIAL*)

Date_____

Check Appropriate Box ❍ Mr. ❍ Mrs. ❍ Miss. ❍ Ms ❍ Dr. ❍ Other

Name_____ Birthdate_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Mailing Address (if different)_____ City_____ State_____ Zip_____

Patient's or Parent's Employer_____ Occupation_____

Business Address_____ Work Phone_____ State_____ Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

If Patient is a Student, Name of School/College_____ City_____ State_____

Whom May We Thank for Referring You?_____

Email Address_____ Emergency Contact_____ Phone_____

# *Responsible Party*

Name of Person Responsible for this Account_____ Relationship to Patient_____

Soc. Sec.#_____ Address_____ Home Phone_____

Employer_____ Work Phone_____

Is this Person Currently a Patient in our Office? ❍ Yes ❍ No

# *Insurance Information* (*Dental only, please*)

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____

Name of Employer_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ ID #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

Phone_____

*ANY ADDITIONAL DENTAL INSURANCE INFORMATION?*

Name of Insured_____ Relationship to patient_____

Birthdate_____ Social Security #_____ Date Employed_____

Name of Employer_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ ID #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

***Please note:** We do not accept assignment of benefits; however we will submit insurance claims for you. Payment from patient is due at time of service.

***Over Please***

# *Patient Medical History*

Physician _____ Office Phone _____ Date of Last Exam _____

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? If so, for what? _____ | ❍ | ❍ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness If yes, please list. _____ | ❍ | ❍ |
| 3. Are you taking any medication(s) including non-prescription medicine? (Aspirin, etc.) If yes, what medication(s) are you taking? _____ | ❍ | ❍ |
| 4. Do you use tobacco? | ❍ | ❍ |
| 5. Are you wearing contact lenses? | ❍ | ❍ |
| 6. Have you ever needed to take antibiotics prior to dental treatment? | ❍ | ❍ |

| | Yes | No |
|---|---|---|
| 7. Are you allergic to or have you had any reactions to the following? | ❍ | ❍ |
| Local Anesthetics (eg. novocaine) | ❍ | ❍ |
| Penicillin or other Antibiotics | ❍ | ❍ |
| Sulfa Drugs | ❍ | ❍ |
| Barbiturates | ❍ | ❍ |
| Sedatives | ❍ | ❍ |
| Iodine | ❍ | ❍ |
| Aspirin | ❍ | ❍ |
| Other | ❍ | ❍ |
| Latex | ❍ | ❍ |
| 8. Women Only: | | |
| a) Are you pregnant or think you may be pregnant? | ❍ | ❍ |
| b) Are you nursing? | ❍ | ❍ |
| c) Are you taking birth control pills? | ❍ | ❍ |

**Do you have or have you had any of the following?**

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | | ❍ | Heart Disease | ❍ | ❍ | Chest Pains | ❍ | ❍ |
| Heart Attack | ❍ | ❍ | Cardiac Pacemaker | ❍ | ❍ | Easily Winded | ❍ | ❍ |
| Rheumatic Fever | ❍ | ❍ | Heart Murmur | ❍ | ❍ | Stroke | ❍ | ❍ |
| Swollen Ankles | ❍ | ❍ | Angina | ❍ | ❍ | Hay Fever / Allergies | ❍ | ❍ |
| Fainting / Seizures | ❍ | ❍ | Frequently Tired | ❍ | ❍ | Tuberculosis | ❍ | ❍ |
| Asthma | ❍ | ❍ | Anemia | ❍ | ❍ | Radiation Therapy | ❍ | ❍ |
| Low Blood Pressure | ❍ | ❍ | Emphysema | ❍ | ❍ | Glaucoma | ❍ | ❍ |
| Epilepsy / Convulsions | ❍ | ❍ | Cancer | ❍ | ❍ | Recent Weight Loss | ❍ | ❍ |
| Leukemia | ❍ | ❍ | Arthritis | ❍ | ❍ | Liver Disease | ❍ | ❍ |
| Diabetes | ❍ | ❍ | Joint Replacement or Implant | ❍ | ❍ | Heart Trouble | ❍ | ❍ |
| Kidney Diseases | ❍ | ❍ | Hepatitis / Jaundice | ❍ | ❍ | Respiratory Problem | ❍ | ❍ |
| AIDS or HIV Infection | ❍ | ❍ | Sexually Transmitted Disease | ❍ | ❍ | Metal Allergies | ❍ | ❍ |
| Thyroid Problem | ❍ | ❍ | Stomach Troubles / Ulcers | ❍ | ❍ | Other: _____ | | |

# *Patient Dental History*

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ❍ | ❍ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ❍ | ❍ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ❍ | ❍ |
| 4. Does your skin react to any kind of jewelry? | ❍ | ❍ |
| 5. Do you have any sores or lumps in or near your mouth? | ❍ | ❍ |
| 6. Have you had any head, neck or jaw injuries? | ❍ | ❍ |
| 7. Have you ever experienced any of the following problems in your jaw? | | |
| a) Clicking | ❍ | ❍ |
| b) Pain (joint, ear, side of face)? | ❍ | ❍ |
| c) Difficulty in opening or closing? | ❍ | ❍ |
| d) Difficulty in chewing? | ❍ | ❍ |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | ❍ | ❍ |
| 9. Do you clench or grind your teeth? | ❍ | ❍ |
| 10. Do you bite your lips or cheeks frequently? | ❍ | ❍ |
| 11. Have you ever had any difficult extractions in the past? | ❍ | ❍ |
| 12. Have you ever had any orthodontic work? | ❍ | ❍ |
| 13. Have you ever had any prolonged bleeding following extractions? | ❍ | ❍ |
| 14. Have you ever had instructions on the correct method of brushing your teeth? | ❍ | ❍ |
| 15. Have you ever had instructions on the care of your gums? | ❍ | ❍ |
| 16. How long since your last dental visit? _____ | | |

# *Authorization and Release*

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize the dental staff to perform the necessary treatment my child may need. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent if minor

*Doctor's Comments* _____

_____

_____ *Signature* _____ *Date* _____