LAKE AREA DENTISTRY

Patient First Name		Patient Last Name
Social Security #	Date of Birth	Gender ☐ MALE ☐ FEMALE
Mailing Address	City, State	Zip Code
Home Phone	Cell Phone	E-mail
Marital Status ☐ SINGLE ☐ MARRIED ☐ MINOR ☐ OTHER		Employment ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ OTHER
Patient Employer		Job Title
Employer Address		Employer Phone
Emergency Contact (Name, Relationship, Phone)		
Primary Insurance Co.		Policy Holder ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER
Subscriber SSN #	Member ID	Group #
Secondary Insurance Co.		Policy Holder ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER
Subscriber SSN #	Member ID	Group #
Person Responsible for Account (if other than patient)		Relationship to Patient
Social Security #	Date of Birth	Job Title
Employer		Employment ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ OTHER
Address (if different from patient)		Phone Number

As a courtesy to our patients, we do file your insurance claims for you. However, it must be stressed that your insurance is a contract between you, your employer, and your insurance company. Our practice is not a party to this contract. While we will do our best to help you receive your maximum benefits, we we will not become involved in disputes between you and your insurance company regarding covered charges, secondary insurance, reasonable and customary determinations, etc. If you have questions about your benefits, please call your insurance company. It would be helpful for you to know your insurance coverage effective date, annual deductible, and annual maximum.

If an insurance company sends a check to you, you are responsible for prompt payment to Lake Area Dentistry in the exact amount of the insurance check, plus any and all additional balance due.

Your estimated copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. This amount is only an estimate and may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Please do not hesitate to ask if you have any questions.

I have read and understand this statement regarding insurance processing and acknowlege that I am ultimately responsible for all account payments.

Print Name of Patient _____ Signature of Patient or Responsible Party _____ Date _____

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Reason for Today's Visit	Last Dental Care Appointment (date, type of treatment)

Previous Dentist	Office Phone #

Office Address	City, State	Zip Code

Any dental x-rays taken in the last 12 months? ☐ YES ☐ NO	Do you have any dental related anxiety? ☐ YES ☐ NO	Have you had orthodontic work? ☐ YES ☐ NO
How often do you brush?	How often do you floss?	Any swelling or lumps in your head or neck? ☐ YES ☐ NO

Check if you have problems with any of the following:

☐ Bleeding gums ☐ Sores or growths in mouth ☐ Food collecting between teeth ☐ Sensitivity to pressure ☐ Sensitivity to hot

☐ Bad breath ☐ Clicking or popping jaw ☐ Sensitivity when brushing ☐ Sensitivity to sweets ☐ Grinding teeth

☐ Loose teeth ☐ Broken teeth or fillings ☐ Periodontal Disease ☐ Sensitivity to cold

What would you like to accomplish with your teeth?

If I could change anything about my smile it would be:

Physician's Name	Office Phone #

Date of last visit	Have you ever had a blood transfusion? ☐ YES ☐ NO If yes, give approximate dates _____

Have you had any serious illness or operations? ☐ YES ☐ NO

If yes, describe _____

List all medications you are currently taking:

_____

_____

_____

_____

Check if you have or ever had any of the following:

☐ Any heart problems ☐ Shortness of breath ☐ Anemia ☐ Herpes ☐ Psychiatric Care ☐ Stroke ☐ Venereal disease

☐ High blood pressure ☐ Anxiety or depression ☐ Arthritis ☐ Hepatitis ☐ Rheumatic Fever ☐ Tonsillitis ☐ History of drug abuse

☐ Low blood pressure ☐ Fainting ☐ Asthma ☐ Measles ☐ Scarlet Fever ☐ Tuberculosis

☐ Circulatory problems ☐ Radiation treatments ☐ Diabetes ☐ Mumps ☐ Sinus problems ☐ Typhoid Fever

☐ Mitral Valve Prolapse (Pre-medicate) ☐ Knee/Hip Replacement (Pre-medicate) ☐ HIV/AIDS ☐ Malignancies ☐ Skin rash ☐ Ulcers

☐ Allergies to anesthetics _____

☐ Allergies to medicines _____

☐ Allergies/Reactions to any not mentioned _____

Women Only:

Are you pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Taking birth control? ☐ YES ☐ NO