

Lakeview Dental

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Name Last		First		Middle	
Address Street or P.O. Box #		City	State	Zip Code	Phone Number: Home: Work:
Pager#:		Cell Phone:		Email Address:	
Age: Yrs.	Birth Date Mo.	Day	Year	() Married	() Unmarried () Separated
Social Security No. (for child, parents)				Preferred Pharmacy	
Occupation		Employer		Address & Phone #	
Person responsible for bill		Age	Address		Relationship
					Social Security No.
Occupation		Employer			How long employed?

INSURANCE INFORMATION

# _____		Date of Birth _____		Social Security _____	
Subscriber's Full Name _____					
Subscriber ID# _____		Work Phone _____			
Group ID# _____		Relationship to Patient _____			
_____		_() _____			
Insurance Company Name _____		Insurance Co. Phone # _____		Insurance Co. Address _____	
Employer Name _____		Full Address of Employer _____			
Please check appropriate box:					
<input type="checkbox"/> 1. As a special service to you, we offer a cash courtesy if you pay for your portion the insurance does not cover. Remember, however, that entire treatment plan in full, in advance. you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us. <input type="checkbox"/> 2. Cash and personal checks are accepted as your treatments are provided.					
<input type="checkbox"/> 4. MasterCard, Visa, Discover, Care Credit					
<input type="checkbox"/> 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and <input type="checkbox"/> 5. For long term or extended payments, we offer a healthcare financing verifying the coverage that your particular program provides. We accept program, which when you are accepted, will allow extended small assignment of your insurance payment; another service to you. monthly payments for the treatment received.					

For all Patients: I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature _____

Under the HIPPA Act of 1996, I am informed of the form *Notice of Private Policies* from Lakeview Dental.

Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 Name of Physician/and their specialty _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to			27. arthritis, rheumatoid arthritis, lupus _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			28. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			29. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfa			32. neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			33. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			35. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. STI / STD _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			37. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy, immunosuppressive _____	<input type="checkbox"/>	<input type="checkbox"/>
7. artificial prosthesis (heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol / street drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	46. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
13. emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47. aware of a change in your health in the last 24 hours		
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	(i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	48. taking medication for weight management (i.e. fen-phen)	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	<input type="checkbox"/>	<input type="checkbox"/>	49. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51. experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	52. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	53. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	55. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c= _____)	<input type="checkbox"/>	<input type="checkbox"/>	56. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than a cleaning) ____/____/____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



- | | | |
|---|--------------------------|--------------------------|
| 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [] _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

GUM AND BONE



- | | | |
|---|--------------------------|--------------------------|
| 7. Do your gums bleed or are they painful when brushing or flossing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is there anyone with a history of periodontal disease in your family? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever experienced gum recession? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you experienced a burning sensation in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

TOOTH STRUCTURE



- | | | |
|--|--------------------------|--------------------------|
| 14. Have you had any cavities within the past 3 years? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have grooves or notches on your teeth near the gum line? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you frequently get food caught between any teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT



- | | | |
|--|--------------------------|--------------------------|
| 21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are your teeth crowding or developing spaces? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you have more than one bite and squeeze to make your teeth fit together? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you clench your teeth in the daytime or make them sore? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you wear or have you ever worn a bite appliance? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE CHARACTERISTICS



- | | | |
|---|--------------------------|--------------------------|
| 31. Is there anything about the appearance of your teeth that you would like to change? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you ever whitened (bleached) your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you been disappointed with the appearance of previous dental work? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____