Lakeside Endodontics

WELCOME

We are pleased to welcome you to our practice. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to ask. Thank you for trusting us with your care.

Date _____

PATIENT INFORMATION

Name _____ Soc. Sec. #_____

Address _____

City _____State _____ Zip _____

Phone # (H) _____ (W) _____ (C) _____

Birthdate _____ Occupation _____

Person to contact in Case of Emergency _____

Relationship to you _____ Phone # (H) _____ (C) _____

Whom May We Thank for Referring You? _____

PRIMARY DENTAL INSURANCE

Insurance Company _____ Group#_____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security# _____ Phone # (H)_____

Address _____

City _____State _____ Zip_____

Employer _____ Business Phone #_____

Business Address _____ City_____State _____ Zip_____

SECONDARY DENTAL INSURANCE

Insurance Company _____ Group # _____

Subscriber Name _____ Relationship to Patient _____

Birthdate _____ Social Security# _____ Phone # (H) _____

Address (if other than Patient) _____

City _____ State _____ Zip _____

Subscriber Employed By _____ Business Phone# _____

(over)

Patient Name:

Dental History

Reason for today's visit _____

Dentist Name _____ Phone #_____

Check Box if you have had problems with any of the following:

____ Bleeding Gums	____ Pain Around Ear	____ Sensitivity to Heat
____ Clicking or Popping Jaw	____ Periodontal Treatment	____ Sensitivity to Sweets
____ Grinding Teeth	____ Sensitivity to Cold	____ Sensitivity when Biting

Health History

Physician's Name _____ Phone # _____

Are you currently under a physician's care? ____ Yes ____ No

If yes, please describe: _____

Are you required to take an antibiotic before dental procedures? ____ Yes ____ No

Women: Are you pregnant? ____ Yes ____ No *Nursing? ____ Yes ____ No* *Taking Birth Control? ____ Yes ____ No*

Place a mark on "Yes" or "No" to indicate if you had any of the following:

AIDS	Yes____	No____	Epilepsy	Yes____	No____	Psychiatric Care	Yes____	No____
Anemia	Yes____	No____	Fainting or Dizziness	Yes____	No____	Radiation Treatment	Yes____	No____
Arthritis, Rheumatism	Yes____	No____	Glaucoma	Yes____	No____	Respiratory Disease	Yes____	No____
Artificial Heart Valves	Yes____	No____	Heart Murmur	Yes____	No____	Rheumatic Fever	Yes____	No____
Artificial Joints	Yes____	No____	Heart Problems	Yes____	No____	Scarlet Fever	Yes____	No____
Asthma	Yes____	No____	Hepatitis	Yes____	No____	Shortness of Breath	Yes____	No____
Back Problems	Yes____	No____	Herpes	Yes____	No____	Sinus Trouble	Yes____	No____
Bleeding Disorder	Yes____	No____	High Blood Pressure	Yes____	No____	Skin Rash	Yes____	No____
Cancer	Yes____	No____	HIV Positive	Yes____	No____	Special Diet	Yes____	No____
Chemical Dependency	Yes____	No____	Jaundice	Yes____	No____	Stroke	Yes____	No____
Chemotherapy	Yes____	No____	Jaw Pain	Yes____	No____	Swelling of Feet/Ankles	Yes____	No____
Circulatory Problems	Yes____	No____	Kidney Disease	Yes____	No____	Swollen Neck Glands	Yes____	No____
Congenital Heart Lesion	Yes____	No____	Liver Disease	Yes____	No____	Thyroid Problems	Yes____	No____
Cortisone	Yes____	No____	Low Blood Pressure	Yes____	No____	Tonsillitis	Yes____	No____
Diabetes	Yes____	No____	Mitral Valve Prolapse	Yes____	No____	Tuberculosis	Yes____	No____
Emphysema	Yes____	No____	Neurological Disorder	Yes____	No____	Ulcer	Yes____	No____

Medications

List Medications you are taking:

_____
_____
_____

Pharmacy Name _____

Phone _____

Allergies

_____ Aspirin	_____ Local Anesthetic
_____ Barbiturates	_____ Penicillin
_____ Codeine	_____ Sulfa
_____ Iodine	_____ Other _____
_____ Latex	_____

Authorization

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. If there are any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without failure.

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I will be charged for appointments cancelled or broken without 24 hours advance notice.

Signature _____ Date _____

Doctor's Signature _____ Date _____