LynbrookSmiles
creating beautiful smiles to last a lifetime

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NEW PATIENT & MEDICAL HISTORY INFORMATION

DATE: / / ❑ MALE ❑ FEMALE BIRTH DATE: SOCIAL SECURITY #:

NAME: STATUS: ❑ MARRIED ❑ SINGE ❑ CHILD ❑ OTHER

CONTACT INFO: HOME PHONE: CELL: EMAIL:

STREET ADDRESS:

CITY: STATE: ZIP CODE:

NAME OF SPOUSE / CLOSEST RELATIVE: REFFERED BY:

Medical History

For the following questions, check YES or NO, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? ❑ Yes ❑ No
2. Any change in your general health within the past year? ❑ Yes ❑ No
3. When was your last physical examination?
4. Are you now under the care of a physician? ❑ Yes ❑ No
   If so, what is the condition being treated?
5. What is the name and address of your physician(s)?
6. Have you had any serious illness, operation, or have you been hospitalized in the past 5 years? ❑ Yes ❑ No
   If so, what is the condition being treated?
7. Are you taking any medicine(s), including all non-prescription medicine(s)? ❑ Yes ❑ No
   If so, what medicine(s) are you taking?
8. Do you have or have had any of the following diseases or problems:
   - A) Damaged heart valves or artificial heart valves ❑ Yes ❑ No
   - B) Heart murmur or rheumatic heart disease ❑ Yes ❑ No
   - C) Cardiovascular disease: heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke? ❑ Yes ❑ No
     - C1) Do you have chest pain upon exertion? ❑ Yes ❑ No
     - C2) Have you ever been short of breath after mild exercise or while lying down? ❑ Yes ❑ No
     - C3) Do your ankles swell? ❑ Yes ❑ No
     - C4) Do you have inborn heart defects? ❑ Yes ❑ No
     - C5) Do you have a cardiac pacemaker? ❑ Yes ❑ No
   - D) Allergy ❑ Yes ❑ No
   - E) Sinus trouble ❑ Yes ❑ No
   - F) Asthma or hay fever ❑ Yes ❑ No
   - G) Fainting spells or seizures. ❑ Yes ❑ No
   - H) Persistent diarrhea or recent weight loss ❑ Yes ❑ No
   - I) Diabetes ❑ Yes ❑ No

J) Hepatitis, jaundice, or liver disease ❑ Yes ❑ No

K) AIDS of HIV infection ❑ Yes ❑ No

L) Thyroid problems ❑ Yes ❑ No

M) Respiratory problems,emphysema, bronchitis, etc. ❑ Yes ❑ No

N) Arthritis or painful swollen joints ❑ Yes ❑ No

O) Stomach ulcer or hyperacidity ❑ Yes ❑ No

P) Kidney trouble ❑ Yes ❑ No

Q) Tuberculosis ❑ Yes ❑ No

R) Persistent cough or cough that produces blood ❑ Yes ❑ No

S) Persistent swollen glands in neck ❑ Yes ❑ No

T) Low blood pressure ❑ Yes ❑ No

U) Sexually transmitted disease ❑ Yes ❑ No

V) Epilepsy or other neurological disease ❑ Yes ❑ No

W) Problems with mental health ❑ Yes ❑ No

X) Cancer ❑ Yes ❑ No

Y) Problems of the immune system ❑ Yes ❑ No

9. Have you had abnormal bleeding? ❑ Yes ❑ No

A) Have you ever required a blood transfusion? ❑ Yes ❑ No

10. Do you have any blood disorder such as anemia? ❑ Yes ❑ No

11. Have you had any treatment for a tumor or growth? ❑ Yes ❑ No

12. Are you allergic or have you had a reaction to:

A) Local anesthetics ❑ Yes ❑ No

B) Penicillin or other antibiotics ❑ Yes ❑ No

C) Sulfa drugs ❑ Yes ❑ No

D) Barbiturates, sedatives, or sleeping pills ❑ Yes ❑ No

E) Aspirin ❑ Yes ❑ No

F) Iodine ❑ Yes ❑ No

G) Codeine or other narcotics ❑ Yes ❑ No

H) Other: _____

_____

13. Any serious trouble with any dental treatment? ❑ Yes ❑ No

If so, explain _____

14. Do you have any disease, condition, or other problem not listed above that we should know about? ❑ Yes ❑ No

If so, explain _____

15. Are you wearing contact lenses? ❑ Yes ❑ No

16. Are you wearing removable dental appliances? ❑ Yes ❑ No

Sleep Apnea

17. Do you snore loudly? ❑ Yes ❑ No

18. Does your bedroom partner complain about your snoring? ❑ Yes ❑ No

19. Does your snoring wake you up at night? ❑ Yes ❑ No

20. Do you or your bedroom partner notice that you make gasping and choking noises in your sleep? ❑ Yes ❑ No

21. Do you have a dry mouth, sore throat or headache in the morning? ❑ Yes ❑ No

22. Do you often fall asleep during the daytime when you want to stay awake? ❑ Yes ❑ No

23. Are you often tired during the day? ❑ Yes ❑ No

24. Do you have high blood pressure? ❑ Yes ❑ No

25. Do you have a history of hypertension? ❑ Yes ❑ No

Women

26. Are you pregnant? ❑ Yes ❑ No

27. Have you had any problems associated with your menstrual period? ❑ Yes ❑ No

28. Are you nursing? ❑ Yes ❑ No

29. Are you taking birth control pills? ❑ Yes ❑ No

Employer's Information

EMPLOYER'S NAME:

OCCUPATION: PHONE:

STREET ADDRESS:

CITY: STATE: ZIP CODE:

Dental Insurance Information

PRIMARY INSURANCE COMPANY'S NAME: PATIENT: ❑ YES ❑ NO

BIRTH DATE OF INSURED: ID #: GROUP #:

INSURANCE COMPANY NAME: PHONE: EMAIL:

STREET ADDRESS: CITY: STATE: ZIP CODE:

SECONDARY INSURANCE COMPANY'S NAME: PATIENT: ❑ YES ❑ NO

BIRTH DATE OF INSURED: ID #: GROUP #:

INSURANCE COMPANY NAME: PHONE: EMAIL:

STREET ADDRESS: CITY: STATE: ZIP CODE:

CONSENT FOR SERVICES

As a condition of your treatment by this office, ***financial arrangements must be made in advance***. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. ***We require 48 hours notice for cancellation of appointments.*** Failure to give proper notice of cancellation will result in a charge at our office's discretion.

Patients who carry dental insurance understand that ***all dental services furnished are charged directly to the patient or guarantor*** and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies will be paid by an insurance company. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, ***I agree to pay*** therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

PATIENT, PARENT, OR GUARDIAN NAME SIGNATURE RELATIONSHIP TO PATIENT

GUARANTOR OF PAYMENT AND/OR RESPONSIBLE PARTY NAME SIGNATURE RELATIONSHIP TO PATIENT