Lowell Family Dentistry- Patient Information

Patient Name: ____ Date: ____________________
Last, First MI (Preferred Name)

Social Security #: _________________________ Birth Date: _______________ Gender: M or F

Drivers License Number: ____________________ Family Status: Single Married Other Child (under 18)

Address: ____
Street City State Zip Code

Phone (Home): _______________ (Work): _______________ Ext: _____ (Cellular): _______________

Texting: Yes or No Mobile Carrier: _________________ Email Address: ________________________

Preferred Method to Confirm Appointments: Home Cell Work Text Email

Date of Last Dental: ______________________ Reason for today's visit: __________________________

Medical History (please check those that apply):

- ☐ AIDS / HIV
- ☐ Allergies
  - ☐ Anesthetic
  - ☐ Epinephrine
  - ☐ Codeine
  - ☐ Latex
  - ☐ Penicillin
  - ☐ Sulfa
  - ☐ Other: ________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints - (specify)
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis – Type____
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ M-V-P
- ☐ Nervous Disorders
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Surgeries: (specify)
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Other: (specify below)

Social History (please check those that apply):

Tobacco Use
Cigarettes: ☐ Never ☐ Quit Date:______
Current Smoker: ☐ Yes ☐ No
#packs/day______ # years______

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use
Do you drink alcohol? ☐ Yes ☐ No
drinks/week________

Specify:____

1. Have you ever had any complications following dental treatment? ☐ Yes ☐ No
   If yes, please explain: ____
2. Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
   If yes, please explain: ____
3. Are you now under the care of a physician? ☐ Yes ☐ No
   If yes, please explain: ____
   Name of Physician: ______________________________ Phone: ______________
4. Do you have any health problems that need further clarification? ☐ Yes ☐ No
   If yes, please explain: ____
5. Please list any medications you are currently taking:_____________________________
6. WOMEN: Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

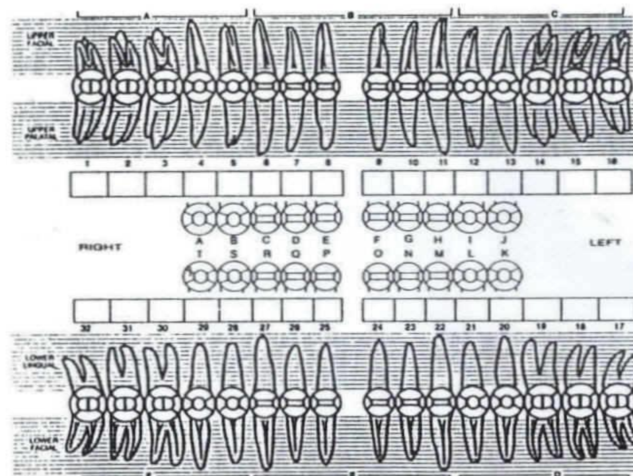
In case of emergency, please contact:____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X____ Date: ______________
Signature of patient, parent or guardian

Tell Us How You Feel About Your Smile

1. Do you like the appearance of your smile? YES / NO
2. Do any of your teeth hurt? YES / NO
   When: ______________________________
3. Do your gums bleed? YES / NO
   When: ______________________
4. Are you happy with the color of your teeth? YES / NO
5. If you could, what would you change about your smile?
   ____



Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

Name of person or office referring you to our practice: ______________________________

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ Sign Outside ☐ Internet ☐ Other __________

Responsible Party Information (if other than patient)

The following is for: ☐ the patient's spouse ☐ the patient's parent ☐ the patient's guarantor

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): __________ (Work): __________ Ext: ____ Best time to call: __________

Address: ______________________________

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________ Occupation: ____________________

Address: ______________________________

Street City, State Zip Code Phone

Insurance Information

No Insurance (check box) ☐

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Insurance Plan Name and Address: ______________________________

____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Insurance Plan Name and Address: ______________________________

Health Industry Patient Portability Act (HIPPA)

I have received and read a copy of this office’s Notice of Privacy Practices. I am giving my consent for Lowell Family Dentistry to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations. I understand that without my signature I cannot receive treatment from Lowell Family Dentistry.

Signature: ______________________________ Date: __________