LUNN DENTISTRY

Welcome to Our Practice

Today's Date _____

Name of Patient _____Birthdate_____Age _____Sex: M__F__SSN_____

Mailing Address _____City_____State_____Zip_____

Home Phone _____Cell _____E-mail address _____

Patient Employed by _____Location_____Work Phone _____

Name of Spouse(If patient is under 21, name of parents)_____

In case of emergency, who should be notified (not your spouse):_____Cell_____

Purpose of today's appointment_____

Would you prefer the office contact you by e-mail, text, cell phone, work phone, home phone? Please circle your choices.

If you are concerned about TMJ or sleep apnea issues, please ask the front desk person for these additional forms.

Insurance Information

Do you have dental insurance? Yes__No__ If yes, name of company_____

Name of policy holder_____Policy holder's SSN _____ _____Birthdate_____

Do you have secondary dental insurance? Yes__No__ If yes, name of company_____

Name of policy holder_____Policy Holder's SSN _____ Birthdate_____

Policy holder's employer _____ Phone _____

Please hand your insurance card to our front desk manager to duplicate .

Medical History

Have you ever had any of the following? Please <u>circle</u> "yes " or "no" for each condition and explain when response is "yes".

No	Joint Replacement	Yes, Explain _____	No	Arthritis	Yes, Explain _____
No	Osteoporosis	Yes, Taking medication? _____	No	Hepatitis	Yes, Explain _____
No	AIDS/HIV Positive	Yes, Explain _____	No	Blood Pressure Issues	Yes, Explain_____
No	Diabetes	Yes, What type? _____	No	Mitral Valve Prolapse	Yes, Explain_____
No	Heart Disease	Yes, Explain _____	No	Heart Surgeries	Yes, Explain_____
No	Heart Murmur	Yes, Explain _____	No	Pacemaker	Yes, Explain _____
No	Endocarditis	Yes, Explain _____	No	Heart Valve Replacement	Yes, When? _____
No	Blood Disease	Yes, Explain _____	No	Hemophilia	Yes, Explain _____
No	Blood Transfusion	Yes, Explain _____	No	Stroke	Yes, Explain _____
No	Epilepsy	Yes, Medicated?_____	No	Cancer	Yes, Explain _____
No	Chemotherapy	Yes, Explain _____	No	Radiation Treatment	Yes, Explain_____
No	Asthma	Yes, Medicated?_____	No	Tuberculosis	Yes, Explain _____
No	Gastric Ulcers	Yes, Explain _____	No	Eye Surgery	Yes, Explain _____
No	Glaucoma	Yes, Explain _____	No	Pregnant	Yes, Due Date_____
No	Herpes	Yes, Type _____	No	STD	Yes, Type_____
No	Kidney Disease	Yes, Explain _____	No	Liver Disease	Yes, Explain _____
No	Use Tobacco Products	Yes, Type _____Frequencies_____	No	Latex Allergy	Yes, Reaction_____

Medical Doctor's Name_____City_____phone_____

Medications you are currently taking:_____

_____

What pharmacy do you prefer? _____Location_____phone_____

List all drugs or medications to which you have a reaction or allergy: _____

_____

Major surgeries and approximate date of surgery: _____

_____

Other medical conditions you have not indicated on page one: _____

_____

PLEASE NOTE: THE TAKING OF ANTIBIOTICS CAN REDUCE THE EFFECTIVENESS OF BIRTH CONTROL

Have you ever been advised to take antibiotics before having your teeth cleaned? Yes___ No___If yes, explain _____

If you have had heart or joint surgery, please list your specialist's name, address and phone number: _____

_____

Is your blood pressure normal? Yes_____ No_____ Date last checked _____

Do you want Nitrous Oxide (laughing gas) to be used for your procedures? Yes_____ No_____

Have you ever had problems with local anesthesia (numbing your teeth)? Yes_____ No_____ Explain _____

Have you had serious problems associated with dental treatment? Yes_____ No_____ Explain_____

Please share with us how you heard about our practice? _____

I, THE UNDERSIGNED, CERTIFY AND ACKNOWLEDGE THE FOLLOWING:

- I assign all third party payments to the payment of Lunn Dentistry.
- I authorize this office to release any health information for the use of treatment, payment, and healthcare operations which includes insurance companies, specialists, and other healthcare providers and institutions.
- I acknowledge that I have been offered a copy of the Practice's Notice of Privacy Practices.
- I am 18 years or older. If you are under 18, your parent or guardian must sign this form.
- I understand that x-rays and other diagnostic tests may be recommended and denial of these tests can result in undiagnosed and untreated oral conditions.
- I am the responsible party and assume responsibility for all the costs, regardless of insurance coverage.
- I assume responsibility for all the costs of collections, including financial charges, attorney fees and court costs.
- I understand that dental insurance companies rarely cover 100% of all dental expenses.
- I have called my insurance company to confirm the coverage I will receive for services rendered at this office.
- I understand that dental treatment carries with it some statistical risks even when performed with the utmost care.
- I understand that appointment times are reserved specifically for me and that any necessary changes should be finalized with the office two working days prior to the original appointment or a late cancellation fee may be charged.
- I have accurately answered all the questions and have read all the above information.

Signature_____ Relationship to Patient_____

Patient Initials	Date Initialed	Provider Initials	Patient BP	Patient Initials	Date Initialed	Provider Initials	Patient BP