Lovettsville Dental Arts

Welcome

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to hep you.
We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Social Security # _____
LAST NAME FIRST NAME INITIAL
Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Sex ❑ M ❑ F Age ____ Birth date _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home Phone _____
Cell Phone _____ Business Phone _____ Email _____

Primary Insurance

Person Responsible for Account _____
LAST NAME FIRST NAME INITIAL
Relation to Patient _____ Birth date _____ Social Security # _____
Address (if different from patient) Street _____ Home Phone _____
City _____ State _____ Zip _____
Cell Phone _____ Email _____
Person Responsible Employed by _____ Occupation _____
Business Address _____
Business Email _____ Business Phone _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group # _____ Subscriber _____
Name of the other dependents under this plan _____

Additional Insurance

Is patience covered by additional insurance? ❑ Yes ❑ No
Subscriber Name _____ Relation to Patient _____ Birth date _____
Address (if different from patient) _____ Social Security # _____
City _____ State _____ Zip _____
Cell Phone _____ Email _____
Subscriber Employed by _____ Business Email _____
Insurance Company _____ Phone _____ Insurance Email _____
Contract # _____ Group # _____ Subscriber _____
Name of the other dependents under this plan _____

_____

PLEASE COMPLETE PAGE 2

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____
Former Dentist _____ Dentist's Phone _____
Address _____ Email Address _____
Date of last dental care _____ Date of last x-rays or digital image _____

Check (✔) Yes or no if you have had problems with any of the following:

❑ **Yes** ❑ **No** Bad breath
❑ **Yes** ❑ **No** Bleeding gums
❑ **Yes** ❑ **No** Clicking or popping jaw
❑ **Yes** ❑ **No** Food collecting between teeth
❑ **Yes** ❑ **No** Grinding or clenching teeth
❑ **Yes** ❑ **No** Loose teeth or broken fillings
❑ **Yes** ❑ **No** Periodontal treatment
❑ **Yes** ❑ **No** Sensitivity to cold
❑ **Yes** ❑ **No** Sensitivity to hot
❑ **Yes** ❑ **No** Sensitivity to sweets
❑ **Yes** ❑ **No** Sensitivity to biting
❑ **Yes** ❑ **No** Sores or growths in mouth

How often do you brush _____Floss? _____
How do you feel about the appearance of your teeth? _____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ **Yes** ❑ **No**
Other information about your dental health or previous treatment _____

Medical History

Physician's Name _____Phone _____
Date of last visit _____ Have you had any serious illnesses or operations? ❑ **Yes** ❑ **No**
If yes describe _____
Are you currently under a physician care? ❑ **Yes** ❑ **No** If Yes Describe _____
Have you ever had a blood transfusion? ❑ **Yes** ❑ **No** If yes approximate dates _____
Have you ever taken Fen-Phen Redux? ❑ **Yes** ❑ **No**
Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva ❑ **Yes** ❑ **No**
Women: Are you pregnant? ❑ **Yes** ❑ **No** Nursing? ❑ **Yes** ❑ **No** Taking birth control pills

Check (✔) Yes or no if you have had any of the following:

❑ **Yes** ❑ **No** AIDS /HIV Positive
❑ **Yes** ❑ **No** Anaphylaxis
❑ **Yes** ❑ **No** Anemia
❑ **Yes** ❑ **No** Arthritis Rheumatism
❑ **Yes** ❑ **No** Artificial heart valves
❑ **Yes** ❑ **No** Artificial joints
❑ **Yes** ❑ **No** Asthma
❑ **Yes** ❑ **No** Atopic (Allergy prone)
❑ **Yes** ❑ **No** Back problems
❑ **Yes** ❑ **No** Blood disease
❑ **Yes** ❑ **No** Cancer
❑ **Yes** ❑ **No** Chemical dependency
❑ **Yes** ❑ **No** Chemotherapy
❑ **Yes** ❑ **No** Circulatory problems
❑ **Yes** ❑ **No** Cortisone treatments
❑ **Yes** ❑ **No** Cough, persistent
❑ **Yes** ❑ **No** Cough up blood
❑ **Yes** ❑ **No** Diabetes
❑ **Yes** ❑ **No** Epilepsy
❑ **Yes** ❑ **No** Fainting
❑ **Yes** ❑ **No** Food Allergies
❑ **Yes** ❑ **No** Glaucoma
❑ **Yes** ❑ **No** Headaches
❑ **Yes** ❑ **No** Heart Murmur
❑ **Yes** ❑ **No** Heart problems
Decribe _____
❑ **Yes** ❑ **No** Hemophilia / Abnormal bleeding
❑ **Yes** ❑ **No** Herpes
❑ **Yes** ❑ **No** Hepatitis
❑ **Yes** ❑ **No** High blood pressure
❑ **Yes** ❑ **No** Jaw Pain
❑ **Yes** ❑ **No** Kidney disease or malfunction
❑ **Yes** ❑ **No** Liver disease
❑ **Yes** ❑ **No** Material Allergies (***latex***, wool, metal, chemicals)
❑ **Yes** ❑ **No** Mitral valve prolapse
❑ **Yes** ❑ **No** Nervous problems
❑ **Yes** ❑ **No** Pacemaker / Heart surgery
❑ **Yes** ❑ **No** Psychiatric care
❑ **Yes** ❑ **No** Rapid weight gain or loss
❑ **Yes** ❑ **No** Radiation treatment
❑ **Yes** ❑ **No** Respiratory disease
❑ **Yes** ❑ **No** Rheumatic / Scarlet fever
❑ **Yes** ❑ **No** Shingles
❑ **Yes** ❑ **No** Shortness of breath
❑ **Yes** ❑ **No** Skin rash
❑ **Yes** ❑ **No** Spina Bifida
❑ **Yes** ❑ **No** Stroke
❑ **Yes** ❑ **No** Surgical implant
❑ **Yes** ❑ **No** Swelling of feet or ankles
❑ **Yes** ❑ **No** Thyroid disease or malfunction
❑ **Yes** ❑ **No** Tobacco habit
❑ **Yes** ❑ **No** Tonsilitis
❑ **Yes** ❑ **No** Tuberculosis
❑ **Yes** ❑ **No** Ulcer / Colitis
❑ **Yes** ❑ **No** Venereal disease

Are you currently taking any medications? If yes list all:
_____
_____

Doyou have any drug allergies? If Yes, list all:
_____
_____

Authorization

I have reviewed the information on the questionnaire, and it is accurate to the best of my knowlegde. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.
I authorize the insurance company indicated on this form 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 the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.
Signature _____ Date _____

Payment is due in full at the time of treatment, unless prior arrangements have been approved.