**Patient Information**

Date:_____

Patient's Name:_____

Last First MI

Preferred Name:_____

Address:_____ Date of Birth:_____

City:_____ State:_____ Zip: _____

Social Security #:_____ Email Address:_____

Home Phone #: _____ Cell #: _____

Occupation:_____

I prefer to be contacted by (circle all that apply): Home phone Cell phone Text Email

Gender: Male Female Marital Status: Married Single Widowed Divorced

Who may we thank for referring you to our office?_____

**Responsible Party Information**

Name: _____

Last First MI

Relationship to patient:_____

**Insurance Information**

Name of insured:_____

Relationship to patient: Self Spouse Child Other

Insured SS# or Alternate ID#:_____ Insured Date of Birth:_____

Name of Insurance Company:_____ Employer:_____

Address: _____ Address: _____

City, State, Zip:_____ City, State, Zip:_____

Phone #:_____ Phone #:_____

## Dental History

The last time I visited the dentist was:_____

I have had a serious problem with previous dental treatment: Yes No

If yes, please explain:

I have serious dental anxiety: Yes No

If yes, please describe:

My primary reason for coming in today is: _____

Have you ever had any of the following:

Periodontal (gum) disease: Yes No Have you received any treatment? Yes No

Loose teeth: Yes No

TMJ (jaw joint) problems: Yes No Have you received any treatment? Yes No

Frequent chipped or broken teeth or restorations? Yes No

Excessive wear: Yes No

Missing teeth that you want replaced? Yes No

Do you wear a nightguard or TMJ Splint? Yes No

Do you like your smile? Yes No

If no, would you like to talk about changing your smile? Yes No

Would you like to have your teeth bleached? Yes No

Would you like to have your teeth straightened? Yes No

My goal for my dental health is:

**Medical History**

Patient Name:_____

Address:_____

Phone Number:_____

Date of Birth:_____

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medication(s) that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions:

Have you ever had any serious head or neck injury ? Yes No

Have you been told to take antibiotics prior to dental treatment? Yes No

If so, why? _____

Do you take blood thinners? Yes No

Have y

ou ever taken: Fosamax, Boniva, Actonel, Prolia or any other medications containing bisphosphonate? Yes No

Do you use tobacco or vape? Yes No

Do you use recreational drugs? Yes No

**WOMEN ONLY**

Pregnant/ trying to become pregnant? Yes NoNursing? Yes No

**ALL PATIENTS**

Are you allergic to any of the following? (Circle All)

Aspirin Amoxicillin Benzocaine Clindamycin Chlorhexidine Hydrocodone

Ibuprofen Latex Local Anesthetics Metal Oxycodone Penicillin

Sulfa drugs (antibiotics) Sulfites (Preservatives) Tetracycline Tylenol

Any other known

allergies?_____

_____

**Please list all medications and supplements that you currently take?**

**Do you have, or have you had, any of the following?**

| | | | |
|---|---|---|---|
| AIDS/HIV positive | Allergies | Alzheimer's | Anaphylaxis |
| Anemia | Angina | Arthritis | Artificial Heart Valve |
| Artificial Joint | Asthma | Blood Disease | Breathing Problems |
| Cancer | Chemotherapy | Chest Pain | Cold Sores |
| Convulsions | Diabetes | Drug Addiction | Eating Disorder |
| Excessive Bleeding | Easily Winded | Emphysema | Epilepsy or seizure |
| Frequent Headaches | Glaucoma | Hard of Hearing | Hay Fever |
| Heart Attack/ Failure | Heart Murmur | Fainting/ Dizziness | Frequent Cough |
| Hemophilia | Hepatitis A | Hepatitis B or C | Herpes (Cold sores) |
| High Blood Pressure | Lung Disease | Thyroid Disease | Sleep Apnea |
| Low Blood Pressure | Sinus Trouble | Sjogren's Syndrome | Pain in Jaw Joints |

Have you had any serious illness not listed? Yes No

If yes, please explain:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to me (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Patient's Signature Date

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I, _____ have received/ read a copy of this office's notice of privacy practices.

I give the following permission to Lost Mountain Dental:
I give this office permission to speak with:_____
Regarding my account billing, dental health and/ or treatment needs. (Excludes medical providers)
I give this office permission to correspond via text and email:

_____ _____

Cell number Email address

_____ _____

Signature of patient Date

_____

Printed name of patient

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**OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice Privacy Practice but acknowledgement could not be obtained because:

_____ Individual to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement