Labrada Dental

GENERAL & COSMETIC DENTISTRY

WELCOME

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to assist you.

Patient Name ______________________________ Date ______________

Address ______________________________ City ____________ State _____ ZIP __________

Birth Date ______/______/________ Social Security # ______________________

Home Ph ______________ Work ______________ Cell ______________ E-mail ______________

Do you prefer to receive calls at?: ☐ **Home** ☐ **Work** ☐ **Cell** ☐ **Other**______________

Are you:: ☐ **Minor** ☐ **Single** ☐ **Married**

Your or your parent's employer ______________________________ Occupation ______________

Employer Address ______________________________ City ____________ State _____ ZIP __________

Spouse's or Parent's Name ______________________________ Phone ______________

If you are a student, name of school/college ______________________________

Person to contact in case of emergency ______________________________ Phone ______________

How did you hear about LABRADA DENTAL?

- ☐ Referral ______________
- ☐ Phone Book
- ☐ Mailing
- ☐ Office sign
- ☐ Newspaper Ad
- ☐ Insurance Company
- ☐ Website
- ☐ Other ______________

Insurance Information

Name of Insured ______________________ SS # ______________ Birth Date ______________

Relationship to Patient ______________________ Subscriber's employer ______________

Address (if different from Patient) ______________________ City __________ State __________ ZIP ______

Insurance Co. ______________________________ Phone ____________ Group ______________

Do you have **ADDITIONAL INSURANCE**? If yes, please provide us with the information

Name of Insured ______________________ SS # ______________ Birth Date ______________

Relationship to Patient ______________________ Subscriber's employer ______________

Address (if different from Patient) ______________________ City __________ State __________ ZIP ______

Insurance Co. ______________________________ Phone ____________ Group ______________

If there were one thing that you could change about your smile, what would it be?

- ☐ Color of your teeth
- ☐ Space between your teeth
- ☐ Shape of your teeth
- ☐ Old fillings or dental work
- ☐ Appearance of your teeth, your smile
- ☐ Alignment of your teeth
- ☐ Biting surface
- ☐ Nothing

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Dental History

Reason for today's visit ____________________

Former Dentist ____________________ City/State ____________________

Date of last exam ____________________ Date of last dental x-rays ____________________

How often do you brush? ____________________ How often do you floss? ____________________

Please check any of the following conditions that apply to you:

- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Gums swollen / tender
- ☐ Blisters on lips or mouth
- ☐ Burning sensation
- ☐ Sensitivity to cold / hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Jaw pain
- ☐ Dry mouth
- ☐ Food collection between teeth
- ☐ Grinding teeth

Health History

Physician's Name ____________________ Phone ____________________ Date of last visit ____________________

List any medications you are currently taking: ____________________

Allergies: ____________________

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control? ☐ Yes ☐ No

Do you have any history of the following? Please check all that apply

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Joints
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe ____________________
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss/Gain

Authorization & Assignment and Release

I certify that I have read and understand the above in formation to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

____________________ ____________________

Signature of patient, parent, guardian or personal representative Date