WELCOME TO LEHIGH DENTAL

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1. ABOUT YOU

Today's Date: _____

Name: _____
(Last) (First) (Middle) (Mr., Mrs., Ms., Dr.)

I prefer to be called: _____ ☐ Male ☐ Female

Birth date: _____ / _____ / _____ Age: _____ SS #: _____

Home Address: _____

_____

☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Home Ph: (_____) _____ Cell/Other Ph: (_____) _____

Work Ph: (_____) _____ Ext: _____ DL#: _____

Employer: _____

Employer's Address: _____

_____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Person Responsible for Account: _____

2. INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birth date: ____ / ____ / _____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

_____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birth date: ____ / ____ / _____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

_____

Payment is due in full at the time of treatment
Unless prior arrangements have been approved

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____ _____
(Signature) (Date)

3. SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Work Ph: (_____) _____ Ext: _____ SS #: _____

Birth date: _____ / _____ / _____ DL #: _____

Emergency Contact

His / Her Name: _____ Relation: _____

Work Ph: (_____) _____ Home Ph: (_____) _____

4. MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (_____) _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Phen-Fen? ☐ Yes ☐ No.
(Also known as Redux or Pondimin)

If so, when? _____

For Women:
Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

☐ Yes ☐ No Abnormal Bleeding / Hemophilia
☐ Yes ☐ No AIDS
☐ Yes ☐ No Alcohol / Drug Abuse
☐ Yes ☐ No Anemia
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Artificial Bone / Joints / Valves
☐ Yes ☐ No Asthma
☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Cancer / Chemotherapy
☐ Yes ☐ No Colitis
☐ Yes ☐ No Congenital Heart Defect
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Difficulty Breathing
☐ Yes ☐ No Herpes / Fever Bisters
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No HIV +
☐ Yes ☐ No Hospitalized for Any Reason
☐ Yes ☐ No Kidney Problems
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Low Blood Pressure
☐ Yes ☐ No Lupus
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Psychiatric Problems
☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Rheumatic / Scarlet Fever

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☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Fainting Spells
☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Hay Fever
☐ Yes ☐ No Heart Attack / Heart Surgery
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Seizures
☐ Yes ☐ No Shingles
☐ Yes ☐ No Sickle Cell Disease / Traits
☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Stroke
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Tuberculosis (TB)
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

☐ Yes ☐ No Aspirin
☐ Yes ☐ No Codeine
☐ Yes ☐ No Latex
☐ Yes ☐ No Erythromycin
☐ Yes ☐ No Jewelry / Metals
☐ Yes ☐ No Dental Anesthetics
☐ Yes ☐ No Penicillin
☐ Yes ☐ No Tetracycline
☐ Yes ☐ No Other

Please list any other drugs / materials that you are allergic to: _____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

Have there been any changes in your health status since your last visit? ☐ Yes ☐ No

If yes, please explain:_____

_____ _____
(Patient Signature) (Date)

_____ _____
(Dentist Signature) (Date)

Have there been any changes in your health status since your last visit? ☐ Yes ☐ No

If yes, please explain:_____

_____ _____
(Patient Signature) (Date)

_____ _____
(Dentist Signature) (Date)

5. DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious / difficult problems associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush Daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMK / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold or anything else? _____

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____ _____

(Signature) (Date)

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OFFICE USE ONLY – OFFICE USE ONLY – OFFICE USE ONLY – OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments

_____

_____

_____

_____

_____

_____