

Lakeshore Dental

Family and Cosmetic Dentistry
A Division of Atlantic Dental Care, PLC

Date _____ Patient Name _____

DOB _____ M/F Marital Status _____ SSN _____

Street Address _____

City _____ Zip Code _____ Email address _____

Phone #'s H: _____ W: _____ C: _____

Employer _____ Occupation _____

Spouse/Parent Name _____ Phone # _____

Nearest Relative Not living with you _____

Address _____ Phone # _____

Responsible Party (If other than Patient) _____ Relationship _____

Address _____ Phone # _____

How did you hear about our office? (Circle One) Internet (our website, ADC website, yellowbook, google),
Location, Insurance List, Postcard campaign, Friend or Family Member (Name) _____

Signature _____
(I authorize treatment)

INSURANCE INFORMATION

Insurance Company _____ Phone number _____

ID # _____ Group # _____

Insured's Name _____ SSN# _____

DOB _____ Employer _____

I have received a copy of the ADC's Notice of Privacy Practices. Name _____

I authorize the electronic transmission of my records. Initial _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO YES NO

1. hospitalization for illness or injury _____
2. an allergic or bad reaction to any of the following:
 aspirin, ibuprofen, acetaminophen, codeine
 penicillin
 erythromycin
 tetracycline
 sulfa
 local anesthetic
 fluoride
 chlorhexidine (CHX)
 metals (nickel, gold, silver, _____)
 latex _____
 nuts _____
 fruit _____
 milk _____
 red dye _____
 other _____
3. heart problems, or cardiac stent within the last six months _____
4. history of infective endocarditis _____
5. artificial heart valve, repaired heart defect (PFO) _____
6. pacemaker or implantable defibrillator _____
7. orthopedic or soft tissue implant (e.g. joint replacement, breast implant) _____
8. heart murmur, rheumatic or scarlet fever _____
9. high or low blood pressure _____
10. a stroke (taking blood thinners) _____
11. anemia or other blood disorder _____
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____
14. chronic ear infections, tuberculosis, measles, chicken pox _____
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____
17. kidney disease _____
18. liver disease or jaundice _____
19. vertigo (e.g. "the room is spinning") _____
20. thyroid, parathyroid disease, or calcium deficiency _____
21. hormone deficiency or imbalance (e.g. polycystic ovarian syndrome) _____
22. high cholesterol or taking statin drugs _____
23. diabetes (HbA1c = _____) _____
24. stomach or duodenal ulcer _____
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____

26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____
27. arthritis or gout _____
28. autoimmune disease
(e.g. rheumatoid arthritis, lupus, scleroderma) _____
29. glaucoma _____
30. contact lenses _____
31. head or neck injuries _____
32. epilepsy, convulsions (seizures) _____
33. neurologic disorders (ADD/ADHD, prion disease) _____
34. viral infections and cold sores _____
35. any lumps or swelling in the mouth _____
36. hives, skin rash, hay fever _____
37. STI/STD/HPV _____
38. hepatitis (type _____) _____
39. HIV/AIDS _____
40. tumor, abnormal growth _____
41. radiation therapy _____
42. chemotherapy, immunosuppressive medication _____
43. emotional difficulties _____
44. psychiatric treatment or antidepressant medication _____
45. concentration problems or ADD/ADHD diagnosis _____
46. alcohol/recreational drug use _____

ARE YOU:

47. presently being treated for any other illness _____
48. aware of a change in your health in the last 24 hours
(e.g., fever, chills, new cough, or diarrhea) _____
49. taking medication for weight management _____
50. taking dietary supplements _____
51. often exhausted or fatigued _____
52. experiencing frequent headaches or chronic pain _____
53. a smoker, smoked previously or other (smokeless tobacco, vaping, e-cigarettes, and cannabis) _____
54. considered a touchy/sensitive person _____
55. often unhappy or depressed _____
56. taking birth control pills _____
57. currently pregnant _____
58. diagnosed with a prostate disorder _____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____