Lakeshore Dental

Family and Cosmetic Dentistry

A Division of Atlantic Dental Care, PLC

Date_____ Patient Name _____

DOB_____ M/F Marita 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 _____ Birth Date _____

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

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

GENERAL INFORMATION

The following is designed to give you some basic information about our practice, which we hope will foster a pleasant and rewarding relationship between you and Dr. Cruser. We have tried to anticipate and provide the answers to many common questions we encounter and will always be happy to answer any questions you may have. Be assured that we will do the utmost to care for your individual dental needs.

OFFICE HOURS AND APPOINTMENTS

Regular office hours are available between 8 am and 6 pm. Your appointments are reserved time for you and you alone. We do our best to provide confirmation and reminder phone calls; however it is not always possible to reach you. It is your responsibility to notify us at least 24 hours in advance if you need to reschedule your appointment. **Appointments missed without proper 24 hour notification may be charged a fee based on the length of the appointment.**

_____ Initial

FINANCIAL POLICY

We are glad to file your insurance claims as a service to you. Our goal is to maximize your insurance benefits. Since we do not have access to your individual policy information, we assume no liability. It is your responsibility to review your individual insurance policy and benefits. All co-payments and deductibles are due at the time of service. The ultimate responsibility for payment is yours. For your convenience, our office accepts Visa, MasterCard, American Express, Discover, checks and cash. There is a service charge on all checks returned for insufficient funds. If you would like to make payments, ask about our financing options through CareCredit. Any accounts over 60 days past due, without prior financial arrangements are subject to an interest charge. If your account is referred to an attorney for collection you agree to pay any attorney and court costs

SIGNATURE _____ DATE _____

Blood Testing: In the event that one of the office staff should accidentally stick themselves with a sharp instrument used in my care, I consent to have my blood tested at the expense of the dental office for possible exposure to bloodborne pathogens so that the affected employee may receive prompt treatment. Results will be kept strickly confidential.

I consent_____

ORAL HEALTH SURVEY

What kind of toothpaste do you use?_____

Do you use a mouthrinse daily?_____

If yes: Which one?_____

Why?_____

Do you consume: Coffee?____ Tea?_____ Red wine?_____ Soda?_____

Use sugar to sweeten your beverages?_____

Chewing gum ? _____

Tobacco, pipe, chewing tobacco?_____

How often do you brush? _____times a day.

How often do you floss? _____

What type of toothbrush do you use? _____

Do you use any mechanical tooth cleaning devices? _____

If yes, which one? _____

Are your gums often tender? _____

Do they bleed? _____

Do you feel that you have bad breath? Circle one: Often Occasionally Seldom,
Only when eating garlic

Do you take vitamins or anti-oxidants regularly? _____