Today's Date:_______________ Age:_______________

Patient's Name:_______________ Date of Birth: _______________

Your answers are for our records only and will be considered confidential.

Please circle yes or no

1. Are you in good health? .... yes no
2. Has there been any change in your health in the past year? .... yes no
3. Are you now under the care of a physician? .... yes no
   if yes, for what condition(s): _______________
4. The name and address of my physician is: _______________
   ____
5. Have you had any serious illnesses or operations in the past 5 years? .... yes no
   if yes, what? _______________
6. Do you have or have you had any of the following diseases or problems?
   a. Rheumatic fever .... yes no
   b. High blood pressure .... yes no
   c. Heart condition or problem .... yes no
   d. Stroke .... yes no
   e. Heart attack .... yes no
   f. Diabetes .... yes no
   g. Asthma or hay fever .... yes no
   h. Sinus trouble .... yes no
   i. Hives or skin rash .... yes no
   j. Frequently thirsty .... yes no
   k. Fainting or seizures .... yes no
   l. Hepatitis .... yes no
   m. Arthritis .... yes no
   n. Tuberculosis .... yes no
   o. Ulcers/colitis .... yes no
   p. Venereal disease .... yes no
   q. Kidney trouble .... yes no
   r. Persistent cough or coughing up blood .... yes no
   s. Bruise easily _______________ yes no

   Explain above conditions: _______________
   ____
7. Have you had abnormal bleeding associated with surgery, injury or tooth extraction? .... yes no
8. Have you ever required a blood transfusion? .... yes no
9. Do you have any artificial body parts (heart valve, hip joint, etc.)? .... yes no
10. Are you taking any medication: .... yes no
    If yes, what? _______________
11. Do you have AIDs or HIV? .... yes no
12. Have you had any chemotherapy or radiation treatments? .... yes no
13. Have you ever experienced an unusual reaction to any of the following drugs?
    a. Local anesthetics .... yes no
    b. Penicillin .... yes no
    c. Aspirin .... yes no
    Other _______________
    d. Codeine .... yes no
    e. Sulfa drugs .... yes no
    f. Barbiturates (sleeping pills) .... yes no
    g. Iodine .... yes no
14. Do your gums bleed when you brush your teeth? .... yes no
15. WOMEN: Are you pregnant? .... yes no
16. Do you have clicking or pain in your jaw joint (TMJ)? .... yes no
17. Have you been told that you have a snoring problem? .... yes no
18. Are you taking antibiotics? .... yes no
19. Do you want to keep your teeth? .... yes no
20. Do you have soreness or swelling under your jaws, arms or any other part of your body? .... yes no
21. Do you have prolonged periods of "feeling sick"? .... yes no
22. Do you have a cardiac pacemaker? .... yes no
23. Do you use tobacco products? .... yes no
24. If yes, are you interested in becoming smoke-free? .... yes no
25. Do you have any disease, condition or problem not listed above that you think we should know about? .... yes no
    If yes, explain: _______________
26. When was the last time your teeth were cleaned professionally by a dental hygienist? _______________
27. Please rate your dental anxiety level on a scale of 1 to 10, with 10 being "extremely anxious" about 1 being "not anxious at all" _______________
28. How did you hear about our office? ☐ Friend or relative (who:) _______________
    ☐ Saw sign while passing ☐ Phone book ☐ Neighborhood association ☐ Mailing

To the best of my knowledge the above information is true and correct.

____
Signature

Patient Information

Date ____________________

Patient Name ____________________ (Last) ____________________ (First) ____________________ (Middle)

Address ____________________ (Street) ____________________ (City) ____________________ (State) ____________________ (Zip)

Phone ____________________ Birthdate ____________________ Social Security # ____________________

If patient is a minor, give parent's or guardian's name ____________________

Whom may we thank for referring you to our office? ____________________

Responsible Party Information

Name ____________________ (Last) ____________________ (First) ____________________ (Middle) ____________________ (Marital Status)

Residence ____________________ (Street) ____________________ (City) ____________________ (State) ____________________ (Zip)

Mailing Address ____________________ (Street) ____________________ (City) ____________________ (State) ____________________ (Zip)

How long at this address ____________ Home Phone ____________________ Alternate Phone ____________________

Previous address (if less than 3 yrs.) ____________________ (Street) ____________________ (City) ____________________ (State) ____________________ (Zip)

Social Security # ____________________ Birthdate ____________________ Relationship to Patient ____________________

Employer ____________________ Occupation ____________________ No. Years Employed ________

Spouses' Name ____________________ (Last) ____________________ (First) ____________________ (Middle) Relationship to Patient ____________________

Employer ____________________ Occupation ____________________ No. Years Employed ________

Social Security # ____________________ Birthdate ____________________ Alternate Phone ____________________

Dental Insurance Information

Policy Holder ____________________ Insured's ID# ____________________

Insurance Company ____________________ Group No. ____________________ Phone # ____________________

Insurance Co. Address ____________________

Do you have dual coverage? Yes ☐ No ☐ If yes:

Policy Holder ____________________ Insured's ID# ____________________

Insurance Company ____________________ Group No. ____________________ Phone # ____________________

Insurance Co. Address ____________________

Insured's Employer ____________________

Emergency Information

Name of nearest relative **NOT** living with you ____________________

Complete Address ____________________

Phone ____________________

While we will assist you in filing any insurance claims, the entire amount of our fees are the patient's responsibility. Any amount failed to pay or contested or denied by the insurance is between the patient and the insurance company. Our service was to the patient and the patient is responsible for the full amount.

Any patient account unpaid after 60 days from the date of service may be charged interest at the rate of 2% per month. In case of failure to pay, we reserve the right to add additional costs like, but not limited to, reasonable collection fees, finance charges, late charges, filing fees, court costs and attorney's fees. These costs are also the patient's responsibility. I understand that credit bureau reports may be obtained.

Signature (Parent's signature if patient is a minor) ____________________

I authorize payment of the dental benefits directly to Lima Road Dentistry, PC. ____________________