Lino Lakes Family Dentistry

Welcome to our family of patients!

Please fill out these forms completely. The better we can communicate, the better we can care for you.

About you (*Information is confidential)*

Date____________ Name ____ I Prefer to be addressed as__________________

Date of Birth ______/_________/___________ Social Security # (For insurance billing only) _________/______/________

Home Address____ City_____________________ State____________ Zip________

Home Phone_____________________________ Work Phone_________________________ Cell Phone____________________

E-mail address____

When and where is the best time to reach you?____

How did you hear about us?____

Person Responsible for this account____ Phone__________________________

Your Employer/School____ Occupation______________________________

Whom should we contact in the event of an emergency? Name_______________________ Phone#_______________________

Dental Insurance (*Please present your card)*

Do you have insurance through your employer? Yes / No

Insurance Company Name________________________________ Subscriber ID#____________________________________

Do you have any other dental insurance? Yes / No

This coverage is through: Spouse/Parent/Other______________________________

Their Name____ Birthdate ____/____/_____ Their SS#___/____/______

Their Employer____ Occupation__________________________________

Insurance Company Name____ Group#__________________________________

PATIENT MEDICAL HISTORY

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Physicians name____ **Date of last visit**_________________

Phone (_____)________________ **Pharmacy**____ **Phone (______)**___________________

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: ____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: ____

Are you now under a doctor's care for a particular problem at this time? Yes No

If yes, why? ____ Date of last physical exam ____/______/_________

Health History Form

Patient's Name ________________________ Date of Birth ____/______/________

Have you ever been hospitalized or had a serious illness? Yes No

If yes, why?____

Have you ever had surgery? Yes No

If yes, when and what for? Date of surgery: ____________ Reason for surgery: ______________

Date of surgery: ____________ Reason for surgery: ______________

Have you been diagnosed with sleep apnea? Yes No

PATIENT MEDICAL HISTORY

Do you have or have you ever had any of the following:

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

If marked yes to any, please explain:

____

____

____

Any cancer, radiation, or chemotherapy? Yes No

Describe: ______________________________Date of your last treatment? ______________

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: ____

____

____

Health History Form

Patient's Name ______________________________ Date of Birth ____/______/________

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No Taking oral contraceptive? Yes No

Due Date__________________ Nursing? Yes No

MEDICATIONS

Are you using any of the following:

Antibiotics? Yes No

Anticoagulants (blood thinners)? Yes No

Heart medications? Yes No

Steroids (cortisone, prednisone, etc.)? Yes No

Antianxiety agents, antidepressants or other psychiatric medications? Yes No

Prescription pain medication? Yes No

Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Yes No

Insulin or oral anti-diabetic drugs? Yes No

Blood pressure medications? Yes No

Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use. Yes No

____

____

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	**Reason for taking**	**Frequency**	**Dosage**

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex? Yes No

Food products? Yes No

Sedatives, barbiturates? Yes No

Acrylic? Yes No

Codeine or other pain killers? Yes No

Aspirin, Motrin, Aleve, or ibuprofen? Yes No

Penicillin or other antibiotics? Yes No

Metal? Yes No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? ____________ Relationship? ______________

Other drug or food allergies not listed above: ____

Health History Form

Patient's Name ______________________________ Date of Birth ____/______/________

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes No If yes, for how long? ______________________

Have you ever sought professional care or been hospitalized for:

Substance abuse? Yes No

Emotional disorders? Yes No

Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often? __________

Marijuana? Yes No How often? __________

Recreational drugs? Yes No How often? __________

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? ______________________

Do you wish to talk to the doctor privately about anything? Yes No

Why have you come to the dentist today? ______________________

When was your last Dental visit? ______________________

When were your teeth last scaled and polished? (cleaned)?

____

When was the last time X-Rays were taken of your teeth? ______________________

Was there any treatment recommended that was not completed? ______________________

Have you ever had orthodontics (braces)? Yes No

Have you ever had periodontal(gum) surgery? Yes No

Have you ever had oral surgery? Yes No

Have you ever experienced pain or discomfort in or around jaw joint (TMJ)? Yes No

Are you anxious or uncomfortable about coming to the dentist? Yes No

Are you currently in pain? Yes No If so, Where ______________________

Do you clench or grind your teeth while awake or sleeping? Yes No

What do you think your major dental needs are at this time? ______________________

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

______________________ Signature of patient, parent, guardian

______________________ Date

______________________ Printed name of patient, parent, guardian/Relationship

______________________ Doctor's Signature

For patients with Insurance

I hereby authorize release of any information relating to any insurance claim and authorize payment directly to Lino Lakes Family Dentistry

______________________ Signature of patient, parent, guardian

______________________ Date