Lovell FAMILY DENTISTRY

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DRS. ERIC & MARY "MIM" LOVELL, DDS

we *Love* to make you smile

NAME

LAST FIRST MI AKA (WHAT YOU PREFER TO BE CALLED)

DATE OF BIRTH
MM/DD/YYYY

☐ MALE
☐ FEMALE

☐ MARRIED
☐ SINGLE
☐ CHILD
☐ OTHER

SOCIAL SECURITY #

ADDRESS

STREET

CITY STATE

ZIP

PHONE

CHECK FOR PREFERED CONTACT

HOME ☐

CELL ☐

WORK ☐

EMERGENCY CONTACT:

NAME PHONE

EMAIL

PRIMARY DENTAL INSURANCE

SUBSCRIBER:

DATE OF BIRTH:

SS# OF SUBSCRIBER:

CARRIER NAME:

SUBSCRIBER ID #:

EMPLOYER:

SECONDARY DENTAL INSURANCE

SUBSCRIBER:

DATE OF BIRTH:

SS# OF SUBSCRIBER:

CARRIER NAME:

SUBSCRIBER ID #:

EMPLOYER:

DENTAL INFORMATION

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY

	Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

What is the reason for your dental visit today?

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of last dental exam? X-ray?

How do you feel about your smile?

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

MEDICAL

Yes No DK

Have you had an orthopedic total joint (hip,knee, elbow, finger) replacement? ☐☐☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax ®) or risedronate (Actonel ®) for osteoporosis or Paget's disease? ☐☐☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐☐☐

Date Treatment began: _____

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve ☐☐☐

Previous infective endocarditis ☐☐☐

Damaged valves in transplanted heart ☐☐☐

Congenital heart disease (CHD)

- Unrepaired, cyanotic CH ☐☐☐
- Repaired (completely) in last 6 months ☐☐☐
- Repaired CHD with residual defects ☐☐☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK		Yes	No	DK
Angina	☐	☐	☐	Mitral valve prolapse	☐	☐	☐
Arteriosclerosis	☐	☐	☐	Pacemaker	☐	☐	☐
Congestive heart failure	☐	☐	☐	Rheumatic fever	☐	☐	☐
Cardiovascular disease	☐	☐	☐	Anemia	☐	☐	☐
Damaged heart valves	☐	☐	☐	Blood transfusion	☐	☐	☐
Heart attack	☐	☐	☐	If yes, date:			
Heart murmur	☐	☐	☐	Hemophilia	☐	☐	☐
Low blood pressure	☐	☐	☐	AIDS or HIV infection	☐	☐	☐
High blood pressure	☐	☐	☐	Arthritis	☐	☐	☐

Yes No DK

Do you use controlled substances (drugs)? ☐☐☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐☐☐

If so, how interested are you in stopping?

(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐☐☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink In a week? _____

	Yes	No	DK		Yes	No	DK
Autoimmune disease	☐	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	Epilepsy	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐	Fainting spells or seizures	☐	☐	☐
Asthma	☐	☐	☐	Neurological disorders	☐	☐	☐
Bronchitis	☐	☐	☐	Sleep disorder	☐	☐	☐
Emphysema	☐	☐	☐	Mental health disorders	☐	☐	☐
Sinus trouble	☐	☐	☐	Specify			
Tuberculosis	☐	☐	☐	Recurrent Infections	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐	Specify			
Chest pain	☐	☐	☐	Kidney problems	☐	☐	☐
Diabetes Type I or II	☐	☐	☐	Osteoporosis	☐	☐	☐
Eating disorder	☐	☐	☐	Persistent swollen glands	☐	☐	☐
Malnutrition	☐	☐	☐	Severe headaches/migraines	☐	☐	☐
Gastrointestinal disease	☐	☐	☐	Severe or rapid weight loss	☐	☐	☐
G.E Reflux/persistent heartburn	☐	☐	☐	Sexually transmitted disease	☐	☐	☐
Ulcers	☐	☐	☐	Excessive urination	☐	☐	☐
Thyroid problems	☐	☐	☐	Stroke	☐	☐	☐
				Glaucoma	☐	☐	☐

WOMEN ONLY Are you:

Pregnant? ☐☐☐

Number of weeks: _____

Taking birth control pills or hormonal replacement? ☐☐☐

Nursing? ☐☐☐

List any Allergies: _____

List any Medications: _____

_____

Primary Care Physician: _____ Date of last physical: _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐☐☐

Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition, or problem not listed above that you think we should know about? ☐☐☐

Explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient healh issues prior to treatment:
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ DATE: _____

PRIVACY POLICY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health informaiton. I understand that this organization has the right to change it's Notice of Privacy Practices at any time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PRINT NAME: _____ RELATIONSHIP: (IF PATIENT IS UNDER 18) _____

SIGNATURE: _____ TODAY'S DATE: _____