LI
Dental Solutions

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Lidentalsolutions.com

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Sex: Male/Female _____

SS#_____ Birth Date: _____

Phone (Cell): _____(Home): _____ (Work)_____Email: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐TH ☐F ☐S

Address: _____
Street Apartment #

_____
City State/Province Zip/Postal Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

OTHER:
☐ _____
☐ Past Surgeries _____

☐ Currently Pregnant?
Due date: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Please List your medications: _____

Are you allergic to any medications? _____Are you on blood thinners_____?

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

Do your gums bleed when you brush or floss? ☐ Yes ☐ No
Are your teeth sensitive to cold, hot, sweets or pressure? ☐ Yes ☐ No
Is your mouth dry? ☐ Yes ☐ No
Have you had any periodontal (gum) treatments? ☐ Yes ☐ No
Have you ever had orthodontic (braces) treatment? ☐ Yes ☐ No
Have you had any problems associated with previous dental treatment? ☐ Yes ☐ No
Do you have earaches or neck pains? ☐ Yes ☐ No
Do you have any clicking, popping or discomfort in the jaw? ☐ Yes ☐ No
Do you brux or grind your teeth?. ☐ Yes ☐ No
Do you have sores or ulcers in your mouth? ☐ Yes ☐ No
Do you wear dentures or partials? ☐ Yes ☐ No
Do you participate in active recreational activities? ☐ Yes ☐ No
Have you ever had a serious injury to your head or mouth? ☐ Yes ☐ No
Are you currently experiencing dental pain or discomfort? ☐ Yes ☐ No

Date of your last dental exam: _____
What was done at that time?_____
Date of last dental x-rays:_____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
(Street / City / State/Province / Zip/Postal Code)

Insured's Employer Name: _____

Address: _____
(Street / City / State /Province / Zip/Postal Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
(Street / City / State/Province / Zip/Postal Code)

Insured's Employer Name: _____

Address: _____
(Street / City / State/Province / Zip/Postal Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian