Belmont Dental Group

James L. Nager, D.M.D. John H. Lapidus, D.M.D.

Date _____

Whom may we thank for this referral?

Patient's Name _____
Last First Middle

Address _____
Street City / State / Zip

Home Phone _____/_____ Cell Phone _____/_____

Email Home _____ Email Work _____

Employer _____ Work Phone _____

Birthdate _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security No._____ Occupation_____

If Minor, List Parents' Names Father _____ Mother _____

IF YOU WOULD LIKE US TO FILE INSURANCE CLAIMS ON YOUR BEHALF, PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION. OTHERWISE, PAYMENT IS THE PATIENT'S RESPONSIBILITY ON THE DAY OF SERVICE. THANK YOU.

Dental Insurance Information

(Please provide a copy of your Dental Insurance Card.)

Do you have Dental Insurance? ☐ YES ☐ NO Name of Insurance Company_____

Dental Insurance Company Address _____
Street City / State / Zip

Name of Policy Holder _____
Last First Middle

Social Security No. _____ Birthdate _____

Employer _____ Group No. _____

Employer Address _____
Street City / State / Zip

Employer Phone _____/_____ Relationship to Patient _____

Emergency Information

Name _____ Relationship _____

Complete Address _____
Street City / State / Zip

Home Phone_____ Work Phone _____

Getting to Know You

Is another member of your family a patient in our practice? Name _____

When was your last dental visit?_____ When was the last time you had complete dental X-rays?_____

Former Dentist: Name, Address, Phone _____

Why did you select our office? _____

We are all very pleased to meet you, and look forward to meeting your friends and family.

For All Patients _____
SIGNATURE (Parent if minor) Relationship Date

Continued

Medical History

Have you been under the care of a medical doctor during the past two years?_____ ☐ YES ☐ NO

Please explain _____

_____

Name of Physician _____ Phone Number _____

Physician's Address_____

Have you ever been hospitalized?_____ ☐ YES ☐ NO

Are you allergic to or made sick by ☐ penicillin ☐ aspirin ☐ codeine

☐ other Please list _____

Have you ever had excessive bleeding requiring special treatment?_____ ☐ YES ☐ NO

Check any of the following which you have had or have at present:

- ☐ Heart Disease or Attack
- ☐ Chest Pain
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Rheumatic Fever
- ☐ Congenital Heart Lesions
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Artificial Joint
- ☐ Anemia
- ☐ Stroke
- ☐ Kidney Trouble
- ☐ Ulcers
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Common Cold
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Liver Disease
- ☐ Hay Fever
- ☐ Allergies or Hives
- ☐ HIV Positive
- ☐ Auto Immune Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Heart Murmur/Mitral Valve
- ☐ Hemophilia
- ☐ Cold Sores or Fever Blisters
- ☐ Epilepsy or Seizures

Are you having dental problems at this time?_____ ☐ YES ☐ NO

If yes, please explain_____

Do you feel very nervous about having dental treatment?_____ ☐ YES ☐ NO

Do you take pre-medication before dental treatment?_____ ☐ YES ☐ NO

If yes, what do you take?_____

List all medications you are taking at this time. _____

_____

Are you a smoker?_____ ☐ YES ☐ NO

Do you have trouble getting numb for dental work?_____ ☐ YES ☐ NO

When you walk up stairs or take a walk, do you ever have to stop because

of pain in your chest, or shortness of breath or because you are very tired?_____ ☐ YES ☐ NO

Do your ankles swell during the day?_____ ☐ YES ☐ NO

Women: Are you pregnant? ☐ YES ☐ NO If yes, what month are you due? _____

Are you taking birth control pills?_____ ☐ YES ☐ NO

Do you have any disease, condition or problem not listed? If so, please list_____

- How do you feel about getting and maintaining a healthy mouth?_____
- How do you feel about the appearance of your teeth?_____
- If you could change anything about your smile, what would you change?_____

For Office Use Only: Updates (date and initial) _____ _____ _____ _____ _____ _____