

WELCOME

DON M. LUNN, D.D.S.

DATE _____

This form **MUST** be filled out **ENTIRELY** in order to receive care in our office. Please Print

Patient Information

Name _____ Preferred Name _____
Last First Middle Maiden
Address _____ City/State/Zip _____
Number/Street
Mailing Address (if different) _____ City/State/Zip _____
Number/Street
 Male Female Date of Birth ____/____/____ Minor Single Married Separated Widowed
Home Number (____) _____ Work Number (____) _____ Social Security Number _____
Cell Number (____) _____ Pager Number (____) _____ E-mail _____
Employer Name _____ Position _____
Employer Address _____
Street Number City/State/Zip

Spouse Information _____ Social Security Number _____
Last First Middle
Address _____ City/State/Zip _____
Number/Street
Employer Name _____ Work Number (____) _____ Position _____
Employer Address _____ Date of Birth ____/____/____
Street Number City/State/Zip

Responsible Party _____ Relationship to Patient _____
Street _____ City/State/Zip _____
Number/Street
Home Number (____) _____ Work Number (____) _____ Social Security Number _____
Employer Name _____ Position _____
Employer Address _____ Date of Birth ____/____/____
Street Number City/State/Zip

Primary Insurance

Insurance Company _____ Group Number _____ Phone Number _____
Address _____ Relationship to Insured _____
Street Number City/State/Zip
Name of Insured _____ Insured's ID# _____ Insured's DOB ____/____/____

Secondary Insurance

Insurance Company _____ Group Number _____ Phone Number _____
Address _____ Relationship to Insured _____
Street Number City/State/Zip
Name of Insured _____ Insured's ID# _____ Insured's DOB ____/____/____

Miscellaneous Information

Whom may we thank for referring you _____ General Dentist _____
Emergency Contact/Name/Phone Number _____
Nearest Relative/Name/Phone Number/Relationship(not living with you) _____
Family Members/Friends seen by us _____

Patient Signature (Guardian/Responsible Party)

Date

Medical History

Patient's Name _____ Date of Birth _____

Although dentistry primarily involves areas in and around your mouth, your mouth is part of your entire body. Any health problems that you may have or medications you may be taking could have a significant impact/interaction with the dentistry that you will be receiving. All information is kept strictly confidential. Please, carefully answer the following questions:

1. Are you currently under a physician's care? Yes or No if yes, name health condition _____

Dr's name: _____ Phone: _____

2. Have you been hospitalized in the past 5 years? Yes No For What? _____

3. **Women only:** Are you pregnant or think you may be pregnant? Yes No Nursing? Yes No

4. Do you have or have you ever had any of the following? (Please check and underline if it is current)

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Broken Jaw |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Pain Jaw TMJ | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> <u>NONE OF THE ABOVE</u> |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> HIV Positive | |

5. Are you allergic or have you had any reactions to the following? (Please check)

Local Anesthetic, please specify: _____

- | | | | | |
|---------------------------------------|---------------------------------------|--|---|------------------------------------|
| <input type="checkbox"/> Antibiotics: | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Cleocin (Clyndamycin) | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Others: | <input type="checkbox"/> Codeine | <input type="checkbox"/> Hydrocodone | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Aspirin |
| | <input type="checkbox"/> Latex Rubber | <input type="checkbox"/> Any metal (nickel, mercury, etc.) | <input type="checkbox"/> Other (please list): _____ | |

6. Are you presently taking blood thinners (Coumadin, etc.)? No Yes Please give INR level: _____

7. Do you need to be pre-medicated with an antibiotic for any reason? _____

8. Are you presently taking any drugs? No Yes Please, provide list of medications: _____

9. Are you currently taking any cancer/osteoporosis medications such as Zometa, Aredia, and Fosamax, that could deter regular healing after dental procedures? Yes No
If yes, what medication are you taking? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I have any changes in Health, or if my medicines change, I will inform the doctor at the next appointment.

Patient's Signature

Date

Dr.'s Initials

Date

Dental History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | |
|----------------------------------|---------------------------|--|--------------------------------|--|
| Reason for today's visit _____ | Bad breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lip or cheek biting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | Bleeding gums | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loose teeth or broken fillings | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | Blisters on lips or mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain, brushing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | Cigarettes Smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Former Dentist _____ | Dry mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| City/State _____ | Fingernail biting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of last dental visit _____ | Food collection between | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to heat | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of last dental X-rays _____ | the teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to sweets | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Grinding teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | How often do you floss? _____ | |
| | Gums swollen or tender | <input type="checkbox"/> Yes <input type="checkbox"/> No | How often do you brush? _____ | |