dental center of lakewood

1 PATIENT INFORMATION

Date _____
SS# _____
Drivers License# _____
Patient Name _____
Last Name
_____
First Name MI
Address _____
City _____
State _____ Zip _____
E-mail _____
Sex ☐ M ☐ F Age _____
Birthdate _____
Married Widowed Single Minor
Separated Divorced
Patient Employer /School _____
Occupation _____
Employer/School Address _____
_____
Employer/School Phone (___) _____
Spouse's Name _____
Birthdate _____
SS # _____
Spouse's Employer _____
Whom may we thank for referring you? _____
_____

2 DENTAL INSURANCE

Who is responsible for this account? _____
_____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Insurance Co. Phone# _____
Subscriber's Name _____
Birthdate _____ SS# _____

3 PHONE NUMBERS

Home (___) _____
Work (___) _____ Ext. _____
Cell (___) _____
Spouse's Work (___) _____
Best time and place to reach you? _____
_____

IN CASE OF EMERGENCY CONTACT
(Specify someone who does not live in your household.)
Name _____
Relationship _____
Home Phone (___) _____
Work Phone (___) _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Spillman all insurance benefits, if any, otherwise payable to me for serviced rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions.

Dr. Spillman may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____
Relationship to Patient

4 DENTAL HISTORY

Reason for today's visit _____
_____
Former Dentist _____
City/State _____

Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No

Date of last dental appt. _____
Date of last dental x-rays _____
Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Loose teeth	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Broken fillings	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Sensitivity when biting	☐ Yes	☐ No
			Sores or growths in mouth	☐ Yes	☐ No

How often do you floss? _____
How often do you brush? _____

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____
Have you ever taken any of the group of drugs collective referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).
☐ Yes ☐ No

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

AIDS/HIV	☐ Yes	☐ No	Fainting/dizziness	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis Type __	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, w/extractions or surgery	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
						Swollen feet/ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen neck glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
						Venereal Disease	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			
Epilepsy	☐ Yes	☐ No						

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____
Are you nursing? ☐ Yes ☐ No
Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____
_____
_____
Pharmacy Name _____
Phone (___) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic
☐ Barbituates (sleeping pills)
☐ Codeine ☐ Penicillin
☐ Iodine ☐ Sulfa
☐ Latex ☐ Other _____

_____
_____