

Island Lake Dental Patient Forms

Patient Information:

Patient Name: _____ Date of Birth: _____
SS#: _____ Phone Number: _____
Address: _____ City: _____ State: _____ ZipCode: _____
Email: _____
Sex: Male _____ Female _____ Other _____

IF PATIENT IS A MINOR-UNDER 18 YEARS OLD

Name of Person Responsible for the account: _____
Relationship to Patient: _____
Address: _____ City: _____ State: _____ ZipCode: _____
Phone Number: _____ Email: _____

DENTAL INSURANCE:

Subscriber Name: _____ DOB: _____
Insurance company: _____
Subscriber/Member ID: _____
Subscriber SSN#: _____
Employer: _____

In Case Of Emergency:

Name: _____
Phone Number: _____
Relationship: _____

Patient Medical History:

Are you under medical treatment now?

Have you been hospitalized for any surgical operation or serious illness within the last 5 years?

Are you currently taking any medication(s) including non-prescribed medicine?

Do you use tobacco?

Do you use controlled substances?

Are you allergic to or have had any reactions to the following:

Local Anesthetics (e.g. Novocaine) - Yes___No___

Penicillin or any other Antibiotics - Yes___No___

Sulfa Drugs - Yes___No___ Barbiturates -Yes___No___

Sedatives - Yes___No___ Iodine -Yes___No___

Aspirin -Yes___No___ Any Metals (e.g. nickel , mercury ,etc) -Yes___No___

Latex Rubber -Yes___No___

Other:_____

WOMEN ONLY:

Are you pregnant or think you may be pregnant ? _____

Are you nursing? _____

Are you taking any oral contraceptives? _____

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD THE FOLLOWING?

High Blood Pressure Heart Attack Rheumatic Fever Swollen Ankles Fainting/Seizures

Asthma Low Blood Pressure Epilepsy/Convulsions Leukemia Diabetes Kidney Diseases

AIDS or HIV Infection Thyroid Problem Heart Disease Cardiac Pacemaker Heart Murmur Angina

Frequently Tired Anemia Emphysema Cancer Arthritis Joint Replacement or Implant

Hepatitis/Jaundice Sexually Transmitted Disease Stomach Troubles/Ulcers Chest Pains

Easily Winded Stroke Hay Fever/Allergies Tuberculosis Radiation Therapy Glaucoma

Recent Weight Loss Liver Disease Heart Trouble Respiratory Problems Mitral Valve Prolapse

OTHER:_____

Patient Dental History : Circle Yes or No

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold liquids/foods? Yes No
3. Are Your teeth sensitive to sweet or sour liquids/foods? Yes No
4. Do you feel pain in any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you ever experienced any of the following problems in your jaw? Clicking Pain (joint, ear, side of face) Difficulty in opening or closing Difficulty in chewing?
Yes No
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth ? Yes No
10. Do you bite your lip or cheeks frequently? Yes No
11. Have you had any difficult extractions in the past? Yes No
12. Do you have prolonged bleeding following an extraction? Yes No
13. Have you had any orthodontic treatment? Yes No
14. Do you wear Dentures or Partials? Yes No
15. Have you received oral hygiene instructions regarding the care of your teeth and gums? Yes No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents:

Signature of patient (or parent/guardian if minor)

Date: