



# PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Providing Doctor: \_\_\_\_\_

## ABOUT YOU

NAME: Last First MI  Male  Female

I prefer to be called: \_\_\_\_\_

BIRTH DATE \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_ SS# \_\_\_\_\_

Single  Married  Student\*\* DL# \_\_\_\_\_

\*\*If student, name of college \_\_\_\_\_  FT  PT

HOME ADDRESS \_\_\_\_\_

City State ZIP

HOME PH# \_\_\_\_\_ CELL \_\_\_\_\_

WORK PH# \_\_\_\_\_ EXT \_\_\_\_\_

eMAIL Address: \_\_\_\_\_

WHERE AND WHEN ARE BEST TIMES TO REACH YOU?  
\_\_\_\_\_

EMPLOYER \_\_\_\_\_

HOW LONG? \_\_\_\_\_ OCCUPATION \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

OTHER FAMILY MEMBERS SEEN BY US: \_\_\_\_\_

## SPOUSE or PARENT INFORMATION

NAME(s) \_\_\_\_\_

EMPLOYER(s) \_\_\_\_\_

WORK PH#(s) \_\_\_\_\_

SS#(s) \_\_\_\_\_

BIRTH DATE(s) \_\_\_\_\_

## FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT:  
\_\_\_\_\_

WORK PH# EXT HOME PH#

BILLING ADDRESS:  
\_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ SS# \_\_\_\_\_

EMPLOYER \_\_\_\_\_

DL# \_\_\_\_\_

## EMERGENCY CONTACT

NAME \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

WORK PH# \_\_\_\_\_

HOME PH# \_\_\_\_\_

## HOW DID YOU BECOME OUR PATIENT?

Dex Yellow Pages

Yellow Book USA

BH Gold Pages

Loftus Dental WEB Site

Personal Referral\*\*

Billboard

Emergency

TV Station \_\_\_\_\_

Radio Station \_\_\_\_\_

Other \_\_\_\_\_

\*\* Whom should we thank for referring you to our practice?  
\_\_\_\_\_

## DENTAL INSURANCE

### PRIMARY DENTAL INSURANCE

EMPLOYEE'S NAME: \_\_\_\_\_

EMPLOYEE'S S.S. #: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

EMPLOYEE'S ADDRESS: \_\_\_\_\_

RELATION TO PATIENT: \_\_\_\_\_

INSURANCE CO.: \_\_\_\_\_

INS. CO. ADDRESS: \_\_\_\_\_

ZIP

INS. CO. PHONE#: ( ) \_\_\_\_\_

GROUP # / ID#: \_\_\_\_\_ / \_\_\_\_\_

INSURED'S EMPLOYER: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

ZIP

EFFECTIVE DATE: \_\_\_\_\_

### SECONDARY DENTAL INSURANCE

EMPLOYEE'S NAME: \_\_\_\_\_

EMPLOYEE'S S.S. #: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

EMPLOYEE'S ADDRESS: \_\_\_\_\_

RELATION TO PATIENT: \_\_\_\_\_

INSURANCE CO.: \_\_\_\_\_

INS. CO. ADDRESS: \_\_\_\_\_

ZIP

INS. CO. PHONE#: ( ) \_\_\_\_\_

GROUP # / ID#: \_\_\_\_\_ / \_\_\_\_\_

INSURED'S EMPLOYER: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

ZIP

EFFECTIVE DATE: \_\_\_\_\_

Please check  those boxes for which the answer is YES. If NO, please leave blank. If unsure, please circle. Thank You.

## PATIENT'S DENTAL HISTORY

**FORMER DENTIST:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
NAME
CITY
PHONE
DATE OF LAST EXAM

When were last dental X-Rays taken?  
 Bite-Wings Date: \_\_\_\_\_ Dentist: \_\_\_\_\_  
 Full Mouth Date: \_\_\_\_\_ Dentist: \_\_\_\_\_

- Do you have a history of dental decay?
- Growths or sore spots in your mouth?
- Do you have dental anxiety?
- Continuous bad breath?

- Do you have a history of:**
- Bleeding or swollen gums?
  - Mouth breathing or snoring?
  - Teeth clenching or grinding?
  - Mouth, tooth, or jaw injury?
  - TMJ Treatment? (i.e. clicking or popping)
  - Dental Implants?

**Is there any sensitivity in your mouth from:**  Heat?  Cold?  Sweets?  Chewing?

Are you concerned about any of the following dental conditions?

- Yellow Teeth
- Stained Teeth
- Missing Teeth
- Cracked Teeth
- Tooth Spaces/Gaps
- Uneven Edges
- Crooked Teeth
- Crowded Teeth
- Chipped Teeth
- Red/Swollen Gums

## PATIENTS MEDICAL HISTORY

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental conditions, but they are all associated with proper oral health care.

**Do you have a history of:**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Chronic sinus | <input type="checkbox"/> Cerebral Palsy             | <input type="checkbox"/> Nephrosis         | <input type="checkbox"/> Fen/Phen or Redux®                          |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Drug or Alcohol Dependency | <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> Circulatory Problems                        |
| <input type="checkbox"/> Mumps         | <input type="checkbox"/> Rheumatic Fever            | <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Radiation Treatments                        |
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Tonsillitis       | <input type="checkbox"/> Chronic Mastoid or Ear Infection            |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Heart Problems or Surgery  | <input type="checkbox"/> Tonsils Out       | <input type="checkbox"/> Psychiatric Treatment                       |
| <input type="checkbox"/> Herpes        | <input type="checkbox"/> Mitral Valve Prolapse      | <input type="checkbox"/> Adenoids Out      | <input type="checkbox"/> Pain in region of the ears                  |
| <input type="checkbox"/> Thyroid       | <input type="checkbox"/> Allergies/Hives            | <input type="checkbox"/> Hemophilia        | <input type="checkbox"/> Artificial Prosthesis (implants)            |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Venereal Disease           | <input type="checkbox"/> Chicken Pox       | <input type="checkbox"/> HIV (Human Immunodeficiency Virus)          |
| <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Joint Replacement          | <input type="checkbox"/> Malignancies      | <input type="checkbox"/> ARC (AIDS Related Complex)                  |
| <input type="checkbox"/> Measles       | <input type="checkbox"/> Low Blood Pressure         | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> AIDS ( Acquired Immune Deficiency Syndrome) |
| <input type="checkbox"/> Jaundice      | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Other _____                                 |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Excessive Bleeding         |  |  |
| <input type="checkbox"/> Seizures      | <input type="checkbox"/> Respiratory Disease        |  |  |

Note any caution or concern you wish to discuss with Dr. Loftus:

Please note any current medical treatment, including: diets, pregnancies, impending operations, history of fainting; or other information you wish to bring to doctor's attention.

\_\_\_\_\_

\_\_\_\_\_

- Is patient allergic to:**
- Sulfa
  - Penicillin
  - Latex Rubber
  - Codeine
  - Aspirin
  - Local Anesthetics, (i.e., novocaine)
  - Metals; rings, earrings, etc.
  - Other \_\_\_\_\_

Circle One

Do you require pre-medication for any medical reason? No Yes  
 Are you interested in sedation dentistry? No Yes  
 Are you a smoker or user of tobacco products? No Yes  
 If Yes, how much per day? \_\_\_\_\_

Physician's Name \_\_\_\_\_

**WOMEN:** Are you currently: pregnant nursing  
taking Oral Contraception

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have been provided a copy of this office's Notice of Privacy Practice. If I chose not to take one, I understand I may receive on at any time.

\_\_\_\_\_  
 PATIENT OR GUARDIAN SIGNATURE DATE

I authorize Loftus Dental Inc. to share my information with:

\_\_\_\_\_  
 NAME(S) AND RELATIONSHIP(S)

MEDICATIONS	
Current	Reason

I AUTHORIZE, WITH MY INFORMED CONSENT, THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICE(S) INDICATED DURING DIAGNOSIS AND TREATMENT. As a condition of treatment by this office, I understand financial arrangements must be made in advance. I understand that I am financially responsible for any balance due, whether I have insurance or not. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. If I carry insurance, I authorize my insurance benefits to be paid directly to the dentist. I also authorize the dentist to release any information required for payment to be made. Finally, I understand that if my account ages beyond 60 days, a handling fee of \$3.00 will be charged monthly on any unpaid balance.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

INITIAL AND DATE EACH TIME INFORMATION IS UPDATED