Limbaugh & Stephenson
FAMILY & IMPLANT DENTISTRY

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Welcome! We are pleased to have the opportunity to treat your dental needs. Please fill out the following information for our records. Thank you.

Name: _____ Sex: _____ Marital Status: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Person Responsible for this Account: _____ Relationship: self spouse parent

Occupation: _____ Employer: _____ Work Phone: _____

Employers Address: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Who should we contact in case of an emergency? _____

Whom may we thank for referring you to our office? _____

Dental Insurance Information

Primary: _____ Secondary: _____

Address: _____ Address: _____

_____ _____

Phone #: _____ Phone #: _____

Employee's Name: _____ Employee's Name: _____

SS#: _____ DOB: _____ SS#: _____ DOB: _____

Relationship to Patient: _____ Relationship to Patient: _____

Employer: _____ Employer: _____

Group Number: _____ Group Number: _____

Policy or Contract #: _____ Policy or Contract #: _____

Dental History

Previous dentist: _____ Last Visit: _____ Have you had regular checkups? _____

Do you have a specific problem that needs attention now? _____

Are your teeth sensitive to: Hot Cold Sweets Chewing (Check all that apply)

Do you like the appearance of your teeth? _____ If you could improve your teeth or smile, what would you do? _____

Do your gums feel tender and swollen or bleed when you brush your teeth? _____ Have you been treated for "gum" disease? _____

Have you lost many teeth? _____ Why? _____ Are you interested in replacing your missing teeth? _____

Are you apprehensive about receiving dental treatment? _____ Do you clinch or grind your teeth? _____ When? _____

Have you ever used oral sedation or nitrous oxide for your dental appointments? _____

Have you ever had any complications during previous dental treatment? _____

Medical History

Are you currently in good health? _____ Physicians Name? _____ Phone Number: _____

Please list any **MEDICATIONS** that you currently take: _____

_____

Are you **ALLERGIC** to or have you had a reaction to any of the following: Latex Local Anesthetics Codeine Penicillin/Amoxicillin

Please list any other allergies: _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, please list: _____

_____

Please tell us if you have had any of the following by checking the appropriate box:

- ❑ Bacterial Endocarditis
- ❑ High Blood Pressure
- ❑ Artificial Heart Valve
- ❑ Heart Murmur/MVP
- ❑ Heart Attack: when _____
- ❑ Angina/Chest Pain
- ❑ Heart Surgery
- ❑ Stroke
- ❑ Congestive Heart Failure
- ❑ Asthma: Ever been hospitalized? _____
- ❑ Respiratory Disease
- ❑ Sinus Problems
- ❑ Tuberculosis
- ❑ Excessive Bleeding
- ❑ Anemia/Blood Disease
- ❑ Joint Replacement
- ❑ Liver Problems/Hepatitis: Type _____
- ❑ Cancer, Tumors
- ❑ Radiation or Chemotherapy
- ❑ Ulcers/Colitis
- ❑ Thyroid Problems
- ❑ Shortness of Breath
- ❑ Diabetes
- ❑ Kidney Problems/Dialysis
- ❑ Epilepsy/Seizures
- ❑ Arthritis/Rheumatism
- ❑ Pregnant _____ months
- ❑ Oral Contraceptives
- ❑ Venereal Disease
- ❑ Fever Blisters
- ❑ Drug/Alcohol Addiction
- ❑ AIDS/HIV
- ❑ Eye Disorders/Glaucoma

Please list any other **MEDICAL CONDITIONS** not mentioned above: _____

_____

_____

Medical History Update

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Treatment Authorization and Release

I consent to treatment as necessary or desirable to care for the patient named above, for diagnosis of dental disease, deformity or treatment of dental emergency. These procedures may include radiographs, models, photographs and intraoral examination. 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 payers 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. I understand it is solely my responsibility to report any changes in the above information to this office. 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 have received a copy of this offices "Notice of Privacy Practices".

Signature: _____ **Date:** _____

Patient/Parent/Guardian