Lakeshore Family Dental Care, S.C.

Welcome to Our Practice

Please complete and sign this confidential patient information form (both sides). Thank you!

Patient Name: _____(circle) Mr. Mrs. Ms. Dr. Rev.

I prefer to be addressed as: _____

Address: _____
Street Address City, St Zip

Telephone: Home: (___)_____ Work: (___)_____ Cell: (___)_____

Where and when is the best time to reach you? _____

(check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Date of Birth ___/___/___ **SS#** ___-___-___
Mo Day Yr

Employer: _____ There for _____ yrs.

Employer Address: _____

Occupation: _____

Who may we thank for referring you? _____

Other family members seen by us?_____

Spouse's Name: _____(circle) Mr. Mrs. Dr. Rev.

Date of Birth: ___/___/___ **SS#** ___-___-___

Telephone: Work (___)_____ Cell (___)_____

Employer: _____ There for _____ yrs.

Employer Address: _____

Occupation: _____

Account Information (for insurance and payment purposes)

Dental Insurance Company _____

Name on Account: ☐ Self ☐ Spouse ☐ Other _____

Payment Plan Preferred: (please check one)

☐ Cash or personal check at time of treatment.

☐ Visa, MasterCard or Discover at time of treatment.

☐ I wish to establish credit with your office for personalized financial arrangements. I authorize a credit history report.

(turn over)

Medical History

My current medical health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you under the care of a physician? ☐ YES ☐ NO

Physician Name: _____

Office Location: _____

Office Telephone: _____

List all medications you take (prescription and over-the-counter):

_____

_____

Female Patients: ☐ Pregnant ☐ Nursing ☐ Using Birth Control _____(type)

Have you ever had any of the following:

☐ Heart Attack ☐ Heart Surgery ☐ Mitral Valve Prolapse ☐ Heart Murmur

☐ Pacemaker	☐ Rheumatic Fever	☐ Scarlet Fever	☐ Hepatitis
☐ Kidney Problems	☐ Cancer	☐ Chemotherapy	☐ Radiation Treatment
☐ HIV/Aids	☐ Shingles	☐ Artificial Joint	☐ Artificial Valve
☐ Fever Blisters	☐ Cold Sores	☐ Stroke	☐ Sinus Trouble
☐ Epilepsy/Seizures	☐ Diabetes	☐ Tuberculosis	☐ Psychiatric Problems
☐ Ulcers	☐ Colitis	☐ Anemia	☐ Drug/Alcohol Dependence
☐ Asthma	☐ Arthritis	☐ Emphysema	☐ Hemophilia/Bleeding
☐ Venereal Disease	☐ Fainting	☐ Glaucoma	☐ Difficulty Breathing
☐ High/Low Blood Pressure		☐ Blood Transfusion	☐ Headaches-severe/frequent

☐ Hospitalized for _____

Allergies: Are you allergic or have you had difficulty with any of the following substances?

☐ Penicillin ☐ Tetracycline ☐ Latex ☐ Aspirin ☐ Codeine ☐ Dental Anesthetic
☐ Sulfa ☐ Erythromycin ☐ Other _____

Do you exercise regularly? ☐ YES ☐ NO

If YES, what do you enjoy doing? _____

The information I have provided is true to the best of my knowledge. I authorize the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

SIGNED: _____ **Date:** _____