

Patient Information

Welcome!



Date: _____

Patient Name:

First Last Middle Initial

Preferred Name: _____ Salutation: _____

Address:

Street (Apt#)

City State Zip

Telephone: (____) _____ (____) _____ (____) _____
Home# Work# Cell#

****Please circle preferred phone #**

Can we text you appointment reminders Yes / No (circle one)

Sex: Male ___ Female ___

Marital Status: Married ___ Single ___ Divorced ___ Separated ___ Widowed ___

Birthdate: ___ / ___ / ___ Age ___ Social Security #: _____

Email: _____

Can we email you appointment reminders? Yes / No (circle one)

Employer: _____ Occupation: _____

Person responsible for account (if other than patient)

Legal Name: _____ Relationship to Patient: _____

Address: _____

Telephone: (____) _____ (____) _____ (____) _____
Home# Work# Cell#

Birthdate: ___ / ___ / ___ Social Security #: _____

Employer: _____ Occupation: _____

Employer Address: _____

(OVER)



Insurance Information

PRIMARY DENTAL INSURANCE INFORMATION:	SECONDARY DENTAL INSURANCE INFORMATION:
Subscriber Name:	Subscriber Name:
Relationship to patient:	Relationship to patient:
Subscriber Social Security:	Subscriber Social Security:
Subscriber Date of Birth:	Subscriber Date of Birth:
Subscriber Employer	Subscriber Employer
DENTAL INSURANCE COMPANY:	DENTAL INSURANCE COMPANY:
Effective Date:	Effective Date:
Address of Dental Insurance Company:	Address of Dental Insurance Company:
Phone Number of Dental Insurance:	Phone Number of Dental Insurance:
Member ID #:	Member ID #:
Group #:	Group #:

Miscellaneous Information

Emergency Contact: _____ **Phone #:** _____
Relationship to patient _____

Have any of your family members been to our office: Yes / No (circle one)
If yes, who? _____
How did you hear about us? (If internet, where? Google/Facebook/Yelp)? _____
OR Whom May We thank for the referral? _____

Authorization
 I hereby authorize payment directly to Lang Dental Group of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Lang Dental Group to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals

Signature of Patient, Parent, or Guardian **Date**





Name: _____ DOB: ____ / ____ / _____

Health problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry you will receive. The following questions will insure that we provide you with accurate care during your visit.

<input type="radio"/> Are you under a physician's care now?	Yes	No	If yes, explain: _____
<input type="radio"/> Have you ever been hospitalized or had a major operation?	Yes	No	If yes, explain: _____
<input type="radio"/> Have you ever had a serious head or neck injury?	Yes	No	If yes, explain: _____
<input type="radio"/> Are you on a special diet?	Yes	No	If yes, explain: _____
<input type="radio"/> Do you use smoke or use snuff?	Yes	No	If yes, explain: _____
<input type="radio"/> Do you use controlled substances?	Yes	No	If yes, explain: _____
<input type="radio"/> Have you ever taken Fosamax/Boniva/Actonel/Bisphosphonates	Yes	No	If yes, explain: _____
<input type="radio"/> Do you consider yourself a nervous patient?	Yes	No	If yes, explain: _____
<input type="radio"/> Have you ever used N2O or a sedative during Treatment?	Yes	No	If yes, explain: _____
<input type="radio"/> Are you taking any medications, supplements, or drugs?	Yes	No	If yes, list: _____

(Additional space on back if needed)

Allergies:

- | | |
|----------------|------------------------|
| ____ Aspirin | ____ Codeine |
| ____ Ibuprofen | ____ Sedatives |
| ____ Iodine | ____ Sulfa Drugs |
| ____ Acrylic | ____ Penicillin |
| ____ Metals | ____ Other antibiotics |
| ____ Latex | ____ Local Anesthetics |
| ____ Milk | ____ Other: |

Women are you:

- ____ Pregnant/Trying to Conceive?
 ____ Taking Contraceptives?
 ____ Nursing?
 ____ Taking Estrogen Therapy?

Do you have any of the following: (CIRCLE)

AIDS/HIV	Chest Pains	Frequent Diarrhea
Alzheimer's/Dementia	Cold Sores	Frequent Headaches
Anaphylaxis	Congenital Heart Disorders	Glaucoma
Anemia	Convulsions	Heart Attack/Failure
Angina	Cortisone Medications	Heart Murmur
Arthritis/Gout	Diabetes: Type I or Type II	Heart Pacemaker
Artificial Heart Valve	Drug Addiction	Heart Trouble/Disease
Artificial Joint	Easily Winded	Hemophilia
Asthma/Breathing Trouble	Emphysema	Hepatitis A, B, or C



Bleeding Issues	Epilepsy/Seizures	Herpes
Bruise Easily	Excessive Thirst	High Blood Pressure
Cancer	Fainting Spells/Dizziness	High Cholesterol
Chemotherapy	Frequent Cough	Hives/Rash
Hypoglycemia	Parathyroid Disease	Sickle Cell Disease
Irregular Heartbeat	Psychiatric Care	Sinus Trouble
Kidney Problems	Radiation Treatment	Spina Bifida
Leukemia	Recent Weight Loss	Stomach/Acid Issues
Liver Disease	Renal Dialysis	Stroke
Low Blood Pressure	Rheumatic Fever	Thyroid Disease
Lung Disease	Rheumatism	Tonsillitis
Mitral Valve Prolapse	Seasonal Allergies	Tuberculosis
Osteoporosis	Scarlet Fever	Tumors or Growths
Pain in Jaw Joints	Shingles	Ulcers

If you have marked any of the illnesses above please explain: _____

Any other serious illness not listed:

Dental Health Questionnaire:

What is the main reason you made an appointment? _____

Do you struggle with dental anxiety/fear? If yes, explain:

Do you like your smile? _____

If you could change something about your smile, what would it be?

Do you have dry mouth or dry eyes? If yes, when do you notice it? _____

Do you wear a partial or denture? If so, how old is it and how does it fit?

Do you snore? _____ Have you been diagnosed with Sleep Apnea? _____

Do you wear a CPAP or other sleep apnea appliance? _____

Authorization

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Parent/Guardian (if under age 18)

Date

Additional Space for Medication List/comments if needed:

(OVER)



Health Information Consent Form



Patient Name: _____ DOB ____/____/____

Consent: By signing this form, you do consent to our use and disclose of your personal health information to carry out treatment, payment activities, and other healthcare operations required by this office. You acknowledge you are aware of our need to share your protected personal health information and have received your patient rights notification explaining in detail our office privacy policy and information sharing policy.

Right to revoke: You have the right to revoke this consent at any time by giving us written notice. We will honor the request as of the day we receive your written notice. Please understand it will not affect any action taken before we received your revocation and we may decline to treat you or to continue treating you if you revoke this consent.

Changes to Privacy Practices: We reserve the right to change our privacy practices described in our Patients Rights Privacy Policy and Information Practices. If we change our practices we will issue a revised Patients Rights Privacy Policy and Information Practice Statement.

Patient Responsibility: We request timely notification of any changes to your personal information we maintain for you, such as but not limited to: health history information, address, telephone number, active insurance policy, or change in employer.

In addition to the above, please list who we may discuss your healthcare information with: (Please print name and relationship, more room on back if needed):

Name Relationship to patient

Name Relationship to patient

Authorization

I have read and understand the above information. I understand that by signing this form I am giving my consent for Lang Dental Group to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

 X

Signature of Patient, Parent, or Guardian *Date*

