John H. Lake, DDS, Inc.
Lake Dental Plaza

PERSONAL INFORMATION

☐ Full-time resident ☐ Part-time resident ☐ Visitor

Name_____ ☐ M ☐ F Nickname_____

Address_____

City_____ State_____ Zip_____

Phone_____ Birthdate_____ Age_____

Driver's Lic. #_____ Social Security #_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name_____

Employer_____ Work Phone_____

Emergency Contact Information:

Name_____

Relationship_____ Phone_____

Name_____

Relationship_____ Phone_____

How did you hear about our practice?_____

BILLING INFORMATION

Name of person responsible for this account?_____

Relationship to Patient_____ Phone_____

Billing Address_____

City_____ State_____ Zip_____

Driver's Lic. #_____ Social Security #_____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment:

Cash • Personal Check • Visa • MasterCard • Discover

Payment is due in full at each appointment.

CONSENT: I agree to be responsible for payment of all services rendered on my behalf or my dependents. Should collection become necessary, responsible party agrees to pay up to an additional 30% collection fee and all legal fees of collection agencies, including fees and court costs.

Signature_____ Date_____

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INSURANCE INFORMATION

Patient's Name_____

Spouse's or Parent's Name_____

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____

Name of Employer_____ Work Phone_____

Insurance Company_____

Group #_____ Policy #_____

Do you have additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____

Name of Employer_____ Work Phone_____

Insurance Company_____

Group #_____ Policy #_____

If student, name of school_____

City_____ State_____

☐ Full-time student ☐ Part-time student Number of units enrolled in_____

ASSIGNMENT OF BENEFITS: I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise paid to me. I understand that my dental insurance carrier may pay less than the actual bill for services.

DISCLAIMER: Insurance coverage is an agreement between the patient and the insurance company. The patient is ultimately responsible for the treatment financially. It is my responsibility to know my insurance benefits and frequency limitations of certain procedures.

INSURANCE POLICY: 35% down payment on work over $350.00 on the day the work is started. Insurance claims not paid within 45 days will be billed to me with payment due to Dr. Lake's office within 10 days. Work that has been preauthorized will require patient's portion to be paid in full when work is started.

Signature_____ Date_____

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HEALTH HISTORY

Name_____ Date of Birth_____

Briefly describe the reason you came to the dentist:_____

_____

Are you in pain now? ..... ☐ Yes ☐ No
How many times per day do you brush your teeth? ..... ☐ 0 ☐ 1 ☐ 2 ☐ 3+
How many times per week do you floss? ..... ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+
Do you use a fluoride toothpaste? ..... ☐ Yes ☐ No
Have you ever received instructions regarding the care of your teeth and gums? ..... ☐ Yes ☐ No
How many sweet/starchy snacks do you eat per day? ..... ☐ 0 ☐ 1 ☐ 2 ☐ 3+
How many acidic beverages (soda, o.j., wine) per day? ..... ☐ 0 ☐ 1 ☐ 2 ☐ 3+
Does your mouth often feel dry? ..... ☐ Yes ☐ No
Have you had a cavity in the last 3 years? ..... ☐ Yes ☐ No
Do your gums bleed when you brush or floss? ..... ☐ Yes ☐ No
Have you ever been diagnosed with periodontitis? ..... ☐ Yes ☐ No
Do you wear a denture or partial? ..... ☐ Yes ☐ No
Do you chew gum regularly? ..... ☐ Yes ☐ No
Do you clench or grind your teeth? ..... ☐ Yes ☐ No
Do you have pain in your jaw joints? ..... ☐ Yes ☐ No
Do you have popping or clicking in your jaw joints? ..... ☐ Yes ☐ No
Do you have difficulty opening/closing your mouth? ..... ☐ Yes ☐ No
Have you had any head, neck, or jaw injuries? ..... ☐ Yes ☐ No
Do you have frequent headaches? ..... ☐ Yes ☐ No
Are your teeth sensitive to sweet or sour liquids/foods? ..... ☐ Yes ☐ No
Do you have any sores or lumps in or near your mouth? ..... ☐ Yes ☐ No
Have you had problems with excessive bleeding following previous dental work? ..... ☐ Yes ☐ No
Have you ever been premedicated with antibiotics for your dental treatment? ..... ☐ Yes ☐ No

Date of last dental exam_____

Previous dentist's name and location_____

Are you under a physician's care now? ..... ☐ Yes ☐ No
If yes, please explain_____

Have you ever been hospitalized or had a major operation? ..... ☐ Yes ☐ No
If yes, please explain_____

_____

_____

Have you taken any medications or herbal supplements during the last three weeks? ..... ☐ Yes ☐ No
If yes, please give names and dosages of each_____

_____

_____

_____

_____

Do you take blood thinners? ..... ☐ Yes ☐ No
Have you ever taken medication for osteoporosis such as Fosamax,
Actonel, or other bisphosphonates? ..... ☐ Yes ☐ No
Do you take, or haven you taken Phen-Fen or Redux? ..... ☐ Yes ☐ No
Are you on a special diet? ..... ☐ Yes ☐ No
Do you use tobacco? ..... ☐ Yes ☐ No
Do you use controlled substances? ..... ☐ Yes ☐ No

Women: Are you pregnant/trying to get pregnant? ..... ☐ Yes ☐ No
Taking oral contraceptives? ..... ☐ Yes ☐ No

Are you allergic to, or have you ever had a negative reaction to, any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local anesthetics
☐ Other:_____

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HEALTH HISTORY

Name_____ Date of Birth_____

Do you have, or have you had, any of the following?

Alzheimer's Disease	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Breathing Problem	☐ Yes	☐ No	Heart Pace Maker	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Easily Winded	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tumors of Growth	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Veneral Disease	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No

CONSENT: I authorize Dr. Lake and staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Lake to make a thorough diagnosis of my dental needs. I also authorize Dr. Lake to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with my needs and outlined by verbal and/or written treatment plans. I further acknowledge that Dr. Lake employ such assistance as he deems fit.

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 payers and/or health practitioners.

Signature of Patient (or parent if minor) _____ Date _____