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WELCOME!! Thank you for selecting us! To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions, or need assistance, please ask us and we will be happy to help.

Find us on **Facebook** for ongoing education & updates on us! Check in with us on **Yelp!** And receive a 'Thank you' Prize!

Today's Date: _____

PATIENT INFORMATION (CONFIDENTIAL) *PATIENT #*_____

Last Name/First Name _____ Preferred Nickname _____

Circle one: Male / Female **Circle one:** Married / Single / Child / Other

Date of Birth: _____/_____/_____ SS#_____ DL# _____

Address_____
(Street) (City) (State) (Zip)

Email:_____ Preferred way to contact you? _____

Phone #s (hm)_____ (work) _____ (cell) _____

☐ Yes, I consent to Loftin Dental using my above contact information to discuss my appointments, dental treatment, insurance and my account. I understand that I can withdraw my consent at any time. (please initial) _____

If Minor, Parent's Name_____ Parent's Phone #_____

EMERGENCY CONTACT: _____Phone #/Email _____

Whom may we thank for referring you? (First/Last Name)_____

INSURANCE INFORMATION

Name of Subscriber _____ Relationship to Patient: _____

Subscriber Birthdate_____/_____/_____ Subscriber Social Security #/ID #_____

Name of Employer _____ Name of Insurance Company _____

Group #_____ Policy/ID#_____

Customer Service Phone #_____

Do you have secondary insurance? If Yes, please complete the following.

Name of Subscriber _____ Relationship to Patient: _____

Subscriber Birthdate_____/_____/_____ Subscriber Social Security #/ID #_____

Name of Employer _____ Name of Insurance Company _____

Group #_____ Policy/ID#_____

Customer Service Phone #_____

PATIENT MEDICAL HISTORY

Doctor's Name _____ Phone # _____ Date of Last Exam_____

1. Are you under medical treatment now? ☐ Yes /No ☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes /No ☐
   a. If yes, please explain_____
3. Are you taking any medication, including bisphosphonates or non-prescription medicine? ☐ Yes /No ☐
   a. If yes, please list _____
4. Are you allergic to or have any reactions to the following:

Local Anesthetics (e.g. Novocain	☐ Yes / No ☐	Sulfa Drugs	☐ Yes / No ☐	Aspirin	☐ Yes / No ☐
Penicillin or other Antibiotics	☐ Yes / No ☐	Barbiturates	☐ Yes / No ☐	Latex Rubber	☐ Yes / No ☐
Any Metals (e.g. nickel, mercury	☐ Yes / No ☐	Sedatives	☐ Yes / No ☐	Other _____	☐ Yes

5. Do you have or have you had any of the following?

High Blood Pressure	☐ Yes / No ☐	Heart Disease	☐ Yes / No ☐	Chest Pains	☐ Yes / No ☐
Heart Attack	☐ Yes / No ☐	Cardiac Pacemaker	☐ Yes / No ☐	Stroke	☐ Yes / No ☐
Rheumatic Fever	☐ Yes / No ☐	Heart Murmur	☐ Yes / No ☐	Hay Fever	☐ Yes / No ☐
Swollen Ankles	☐ Yes / No ☐	Angina	☐ Yes / No ☐	Tuberculosis	☐ Yes / No ☐
Fainting/Seizures	☐ Yes / No ☐	Sleep Apnea	☐ Yes / No ☐	Cancer	☐ Yes / No ☐
Asthma	☐ Yes / No ☐	Anemia	☐ Yes / No ☐	Glaucoma	☐ Yes / No ☐
Radiation Therapy	☐ Yes / No ☐	Epilepsy/Convulsions	☐ Yes / No ☐	Liver Disease	☐ Yes / No ☐
Low Blood Pressure	☐ Yes / No ☐	Emphysema	☐ Yes / No ☐	Diabetes	☐ Yes / No ☐
Bleeding Disorders	☐ Yes / No ☐	Leukemia	☐ Yes / No ☐	Thyroid Problem	☐ Yes / No ☐
Joint Replacement/Implant	☐ Yes / No ☐	Arthritis	☐ Yes / No ☐	Other _____	☐ Yes
Respiratory Problems	☐ Yes / No ☐	Kidney Disease	☐ Yes / No ☐		
Mitral Valve Prolapse	☐ Yes / No ☐	AIDS/HIV infection	☐ Yes / No ☐		
Hepatitis/Jaundice	☐ Yes / No ☐	Stomach Problems	☐ Yes / No ☐		

6. Have you ever taken Phen-Fen / Redux? ☐ Yes /No ☐
7. Do you use tobacco? ☐ Yes /No ☐
8. Do you use any controlled substances? ☐ Yes /No ☐
9. Are you wearing contact lenses? ☐ Yes /No ☐
10. **Women ONLY**: Are you pregnant or think you may be pregnant? ☐ Yes / No ☐
    a. Are you nursing? ☐ Yes / No ☐ b. Are you taking oral contraceptives? ☐ Yes / No ☐

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing? ☐ Yes / No ☐
2. Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes / No ☐
3. Are your teeth sensitive to sweet or sour liquids/foods? ☐ Yes / No ☐
4. Do you feel pain in any of your teeth? ☐ Yes / No ☐
5. Do you have any sores or lumps in or near your mouth? ☐ Yes / No ☐
6. Have you had any head, neck or jaw injuries? ☐ Yes / No ☐
7. Have you ever experienced any of the following problems in your jaw? (Circle all that apply)
   Clicking, Pain (joint, ear, side of face), Difficulty in opening or closing, Difficulty in chewing
8. Do you have frequent headaches? ☐ Yes / No ☐
9. Do you clench or grind your teeth? ☐ Yes / No ☐
10. Do you bite your lips or cheeks frequently? ☐ Yes / No ☐
11. Have you ever had any difficult extractions in the past? ☐ Yes / No ☐
12. Have you ever had any orthodontic treatment? ☐ Yes / No ☐
13. Have you had any prolonged bleeding following extractions? ☐ Yes / No ☐
14. Do you wear dentures or partials? If yes, date of placement _____ ☐ Yes / No ☐
15. Do you like your smile? ☐ Yes / No ☐

Authorization and Release

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 of 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.

X_____ X_____

Signature of patient (or parent if minor) / Date *Doctor's Signature / Date*