Family Patient Information

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

Patient Name	Middle Name	Last Name	SSN/ID: DOB:
Patient/Child's Name:	☐Male ☐Female		SSN/ID: DOB:
Patient/Child's Name:	☐Male ☐Female		SSN/ID: DOB:
Patient/Child's Name:	☐Male ☐Female		SSN/ID: DOB:
Home Address	City	State	Zip
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

Whom may we thank for referring you? Name:_____

In case of an emergency who should be notified? Name: _____ Phone:_____

Person Responsible For Account ~ ☐Check Here If Same As Above

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number:			Date of Birth:
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

Dental Insurance Information

☐Check here if you do not have Dental Insurance ☐Check here if you provided an insurance card to be on file

Insured's First & Last Name	Date of Birth	Social Security	
of Insured's Employer		Patient Relationship To Insured	
Insurance Company	Phone	Subscriber ID #	Group ID #
Insurance Company Address	City	State	Zip

Hippa Acknowledgement:Please Initial _____ I understand that I can ask and receive a copy of this office's Notice of Privacy practices.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr Lloyd all insurance benefits, and assign directly to Dr Lloyd all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

Dr Lloyd may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will stay in effect until patient revokes consent verbally or in writing. It immediately ends when patient discontinues services at our practice.

Signature of patient/parent/guardian_____

Print Name:_____ Date:_____

MEDICAL HISTORY

Patients Name: _____ *Office Use: If two patients with same name DOB:*

Please check any of the following that apply to you:

☐Anemia
☐Arthritis/Rheumatism
☐Artificial Heart/Valve
☐Artificial Joints
☐Asthma
☐Back Problems
☐ Blood Disease
☐ Blood Transfusion
☐ Bruise Easily
☐Cancer
☐Chemical Dependency
☐Chemotherapy
☐Circulatory Problems
☐Cortisone Treatments
☐Cough, Persistent
☐Cough up blood
☐Diabetes
☐Dizziness/Fainting
☐Drug Addiction
☐Emphysema
☐Epilepsy
☐Glaucoma
☐Headaches or Migraines
☐ Heart Conditions
☐ Heart Lesions (Congenital)
☐ Heart Murmur
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis A, B or C
☐ High Blood Pressure
☐ HIV/AIDS
☐Jaundice
☐Jaw/Joint Pain
☐Kidney Disease
☐ Liver Disease
☐Low Blood Pressure
☐ Mitral Valve Prolapse
☐Nervousness/Depression
☐Pacemaker
☐ Phen Fen (1 month +)
☐ Radiation (head/neck)
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Shortness of Breath
☐ Skin rash
☐Stomach Problems
☐Stroke
☐Swelling of feet or ankles
☐Thyroid Problems
☐ Tonsilitis
☐Tuberculosis
☐Ulcers
☐ Venereal Diseases
☐ Other:

Women Only:
☐Pregnant Currently
☐ Nursing
☐ Birth Control

Do you have any of the following allergies? Yes/No
☐Allergies (Seasonal)
☐Aspirin
☐Barbiturates (sleeping pills)
☐ Darvon
☐Nitrous Oxide
☐Percodan
☐Local Anesthetic
☐Codeine
☐Latex
☐Erythromycin
☐Valium
☐penicillin
☐Sulfa
☐Other

Are you under a physician's care? Explain what for?
Physician's Name:
_____

_____

List ALL medications you currently take (Rx & Over the counter) or attach list?
_____

_____

Please check any of the following drugs you have used at any time:

Yes or No			Yes or No			Yes or No			Yes or No	
☐	☐	Fosamax	☐	☐	Didronel	☐	☐	Zometa	☐	☐ Boniva
☐	☐	Aredia	☐	☐	Actonel	☐	☐	Skelid		

Is there any other medical or dental information we should know about? **Any surgeries or serious illness?**

_____

Using the Epworth Sleepiness Scale of 0-3 How likely are you to doze off or fall asleep in the following situations?

No chance of dozing = 0 Slight chance of dozing = 1 Moderate chance of dozing = 2 High chance of dozing = 3

__ Sitting and reading
__ Watching TV
__ Sitting in a public place, ie...theater or a meeting
__ As a passenger in a car for an hour without a break
__ Lying down to rest in the afternoon if conditions permit
__ Sitting and talking to someone
__ Sitting quietly after lunch without alcohol
__ In a car, while stopped for a few minutes in traffic

The above information is accurate and complete to the best of my knowledge . I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of the form.

Signature(Patient/Guardian/Parent) Date: Dentist Signature Date: