

# LUKIN FAMILY DENTISTRY

Today's Date: \_\_\_\_\_

## ABOUT YOU

**Name:** \_\_\_\_\_

( ) Male ( ) Female I prefer to be called: \_\_\_\_\_

( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

**Home Address:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_

Where & when are the best times to reach you during the day? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Employer:** \_\_\_\_\_

Employer's Address (Street/ PO Box): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN YOURSELF

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Street: \_\_\_\_\_

City

State

Zip

### DENTAL INSURANCE INFORMATION

Do you have Dental Coverage?       YES       NO

Name of member: \_\_\_\_\_

ID Number: \_\_\_\_\_      DOB of insured: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Group Number: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Customer Service Phone Number: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Are you covered by more than one insurance policy?       YES       NO

### DENTAL HISTORY

- Why have you come in to the dentist today? \_\_\_\_\_
- Are you currently in pain?       Yes       No
- Do you require antibiotics before dental treatment?       Yes       No
- Have you experienced problems associated with any previous dental work?  Yes  No
- Have you ever experienced pain/discomfort in your jaw joint? (TMJ/TMD)?  Yes  No
- Your current dental health is:       Good       Fair       Poor
- Do you brush daily?       Yes       No
- Do you floss daily?       Yes       No
- Type of bristles on your toothbrush?       Hard       Medium       Soft
- How long do you use a toothbrush before replacing it? \_\_\_\_\_
- Do you use anything in addition to you brush and floss?       Yes       No
- If yes, what? \_\_\_\_\_
- Would you like whiter teeth?       Yes       No
- Do your gums ever bleed?       Yes       No
- Have you ever had periodontal disease?       Yes       No
- Do you have mobility in your teeth?       Yes       No
- Do you snore at night?       Yes       No
- Are your teeth sensitive to heat, cold or anything else?  Yes       No
- Do you still have wisdom teeth?  Yes       No
- Previous/Present Dentist: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

- Are you happy with the way your smile looks? ( ) Yes ( ) No
- If not, what would you like to change? \_\_\_\_\_

**MEDICAL HISTORY**

Do you have a personal physician? ( ) Yes ( ) No

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

- Your current physical health is: ( ) Good ( ) Fair ( ) Poor
- Are you currently under the care of a physician? ( ) Yes ( ) No

Please explain: \_\_\_\_\_

- Do you smoke or use tobacco in any other form? ( ) Yes ( ) No
- Are you allergic to any of the following?
 

( ) Yes	( ) No	Aspirin	( ) Yes	( ) No	Latex
( ) Yes	( ) No	Barbiturates	( ) Yes	( ) No	Penicillin
( ) Yes	( ) No	Codeine	( ) Yes	( ) No	Sedatives
( ) Yes	( ) No	Dental Anesthetics	( ) Yes	( ) No	Sulfa Drugs
( ) Yes	( ) No	Erythromycin	( ) Yes	( ) No	Tetracycline
( ) Yes	( ) No	Jewelry/Metals	( ) Yes	( ) No	Other

Please list additional drugs/materials that cause allergic reactions: \_\_\_\_\_

\_\_\_\_\_

**Are you taking any of the following?**

- |                                |                        |                            |
|--------------------------------|------------------------|----------------------------|
| Y N Acetaminophen              | Y N Blood Thinners     | Y N Insulin/Diabetes Drugs |
| Y N Nitroglycerin              | Y N Tranquilizers      | Y N Antihistamines         |
| Y N Cold Remedies              | Y N Recreational Drugs | Y N Aspirin                |
| Y N Digitalis/Heart Medication |                        | Y N Steroids/Cortisone     |

- Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamin or minerals not listed above? ( ) Yes ( ) No
- If yes, please list each one: \_\_\_\_\_

**Do you have or have you experienced any of the following?**

- |  |                         |                             |
|--|-------------------------|-----------------------------|
| Y N Heart Attack                         | Y N Heart Surgery       | Y N Anemia                  |
| Y N Hepatitis                            | Y N Kidney Disease      | Y N Liver Disease           |
| Y N Thyroid Problems                     | Y N Sickle Cell Disease | Y N Congenital Heart Defect |
| Y N Heart Murmur                         | Y N Diabetes            | Y N Lupus                   |
| Y N Mitral Valve Prolapse                | Y N Asthma              | Y N Tumor or Growth         |
| Y N Chemotherapy                         | Y N Emphysema           | Y N High/Low Blood Pressure |
| Y N Pacemaker                            | Y N Arthritis           | Y N Radiation Therapy       |
| Y N Artificial Heart Valves              | Y N Tuberculosis        | Y N Venereal Disease        |
| Y N Blood Transfusion                    | Y N Ulcers              | Y N HIV+/AIDS               |
| Y N Rheumatic Fever                      | Y N Seizures            | Y N Drug/Alcohol Abuse      |
| Y N Stroke                               | Y N Sinus Problems      | Y N Glaucoma                |
| Y N Abnormal Bleeding                    | Y N Headaches           | Y N Artificial Joints       |
| Y N Hospitalization for any other reason |                         |                             |

**FOR WOMEN:**

- Are you taking birth control pills?     Yes             No
- Are you pregnant?     Unsure             Yes             No    Week Number: \_\_\_\_\_
- Are you nursing?                             Yes             No

**AUTHORIZATION**

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

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Signature	Date
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I certify that I am covered by \_\_\_\_\_ Insurance Co. and I assign directly to Dr. Lukin all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

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Signature	Date
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