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.

_____

Signature Date

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 my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendererd on my behalf or my dependents. 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.

_____

Signature Date

STOP BANG Questionnaire

Name _____

S noring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

☐ Yes ☐ No

T ired: Do you often feel tired, fatigued, or sleepy during the day?

☐ Yes ☐ No

O bserved: Has anyone observed that you stop breathing during your sleep?

☐ Yes ☐ No

Blood P ressure: Do you have or are you being treated for high blood pressure?

☐ Yes ☐ No

B MI more than 35 kg/m^2?

☐ Yes ☐ No

A ge over 50 years?

☐ Yes ☐ No

N eck circumference greater than 40 cm?

☐ Yes ☐ No ☐ Unknown

G ender, male?

☐ Yes ☐ No

High risk of obstructive sleep apnea = answering "yes" to 3 or more questions

Lukin Family Dentistry

Department of State Health Services Notice of Privacy Practices

ACKNOWLEDGEMENT OF REVIEW

Date: _____

I have reviewed the Department of State Health Services Notice of Privacy Practices (version effective September 1, 2017), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____

Personal Representative (Print) Personal Representative Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please be specific):

_____

_____

_____ _____

Employee Signature Date

SAVE FORM