MEDICAL HISTORY:

DO YOU HAVE ANY GENERAL HEALTH PROBLEMS? YES ❑ NO ❑
IF SO, PLEASE SPECIFY: _____

HAVE YOU HAD SURGERY OR BEEN HOSPITALIZED IN THE LAST FIVE (5) YEARS? YES ❑ NO ❑
IF SO, PLEASE SPECIFY: _____

HAVE YOU HAD ANY PROSTHETIC JOINT OR BONE REPLACEMENTS? YES ❑ NO ❑
IF SO, PLEASE SPECIFY: _____

ARE YOU CURRENTLY UNDER PHYSICIANS CARE? YES ❑ NO ❑
IF SO, PLEASE SPECIFY: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES ❑ NO ❑
IF SO, PLEASE SPECIFY: _____

ARE YOU CURRENTLY TAKING OR HAVE YOU EVER TAKEN BISPHOSPHONATES FOR OSTEOPOROSIS THERAPY YES ❑ NO ❑

TO THE BEST OF YOUR KNOWLEDGE, ARE YOU OR HAVE YOU EVER BEEN AFFLICTED WITH:

HEART AILMENT? OR PACEMAKER? YES ❑ NO ❑
IF SO, PLEASE SPECIFY: _____

DIABETES? YES ❑ NO ❑

EPILEPSY? YES ❑ NO ❑

HIGH BLOOD PRESSURE? YES ❑ NO ❑

RESPIRATORY DISEASE? YES ❑ NO ❑
(SUCH AS TUBERCULOSIS, BUT NOT LIMITED TO)

BLOOD DISORDERS?
HEPATITIS? (type:____) YES ❑ NO ❑
AIDS? YES ❑ NO ❑
PROLONGED BLEEDING? YES ❑ NO ❑

HEALING COMPLICATIONS? YES ❑ NO ❑

ALLERGY TO ANY DRUGS OR MEDICATION? YES ❑ NO ❑
IF SO, PLEASE SPECIFY: _____

SIGNATURE: _____

REVIEWED BY: _____

DATE: _____

LEE DENTAL ASSOCIATES, Ltd.

We would like to get to know you better!

DATE: _____

NAME: _____

RESIDENCE: _____

_____

PHONE: HOME: _____

CELL: _____

WORK: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

E-MAIL: _____

OCCUPATION: _____

EMPLOYER: _____

ADDRESS: _____

PHONE: _____

SPOUSE'S NAME: _____

SPOUSE'S SOCIAL SECURITY #: _____

OCCUPATION: _____

EMPLOYER: _____

ADDRESS: _____

PHONE: WORK: _____

WHO REFERRED YOU TO OUR OFFICE?

_____

IN CASE OF AN EMERGENCY, WHO CAN WE CONTACT (SOMEONE NOT LIVING WITH YOU):

NAME: _____

PHONE NUMBER: _____

PERSON RESPONSIBLE FOR DENTAL INVESTMENT:

_____

SIGNATURE: _____

DO YOU HAVE DENTAL INSURANCE TO HELP YOU WITH THE COST OF YOUR DENTAL TREATMENT?

❑ YES ❑ NO

NAME OF CARRIER: _____

EMPLOYER: _____

ID #: _____

GROUP NUMBER: _____

ARE YOU COVERED BY ANOTHER PLAN?

❑ YES ❑ NO

IF SO, NAME OF CARRIER: _____

ID #: _____

GROUP NUMBER: _____

We are pleased that you have insurance!

Your dental program will assist you in obtaining and maintaining a superlative level of oral health.

Our office staff "understands" Dental Insurance, and we will be glad to assist you in obtaining the maximum benefits specified in your contract.

You must realize, however, that:

1. Your dental benefit program is a contract between you, your employer and the insurance company. ***We are not a party to that contract.***
2. ***Our fees may not necessarily be covered in full*** by the maximum allowance determined by your carrier.
3. ***Not all dental services are a covered benefit in all contracts***
4. ***You are responsible to us for all our fees for services rendered to you***

Any of us will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care.

OFFICE FINANCIAL POLICY:

Payment is expected, in full, at the time services are rendered, unless specific financial arrangements are made in advance. Failure to comply will result in a 1.5% per month service fee on all balances over 30 days. Accounts not settled within 90 days will be referred to an outside collection facility. All accounting and legal fees incurred by this office will be added to the patient's balance.

INITIALS_____

DENTAL HISTORY:

WHAT IS THE REASON FOR YOUR VISIT TODAY?

_____

WHEN WAS YOUR LAST DENTAL APPOINTMENT AND WHAT WAS DONE AT THAT VISIT?

_____

WHY DID YOU LEAVE YOUR LAST DENTIST?

_____

ARE YOUR TEETH SENSITIVE TO:

HEAT?	YES ❑	NO ❑
COLD?	YES ❑	NO ❑
SWEETS?	YES ❑	NO ❑
BITING PRESSURE?	YES ❑	NO ❑

DO YOUR GUMS BLEED WHEN BRUSHING? YES ❑ NO ❑

HAVE YOU NOTICED ANY SWELLING IN YOUR MOUTH? YES ❑ NO ❑

ARE YOU DISSATISFIED WITH YOUR TEETH AND THEIR APPEARANCE? YES ❑ NO ❑

DO YOU SMOKE? CHEW? OR USE OTHER FORMS OF TOBACCO? YES ❑ NO ❑

DO YOU DRINK ALCOHOLIC BEVERAGES MORE THAN ONE (1) PER DAY? - YES ❑ NO ❑

HAVE YOU HAD A REACTION TO LOCAL ANESTHESIA? YES ❑ NO ❑

DO YOU FEEL YOU WILL EVENTUALLY WEAR ARTIFICIAL DENTURES? YES ❑ NO ❑

INITIALS_____