LACEY – ANTHOLZ – DONNER DENTISTS, P.C.

Name: ____________________ Birthdate: ____________ Today's Date: ____________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication you may be taking could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Question		If yes
Are you under a physician's care now?	O Yes O No	If yes: ____________
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes: ____________
Have you ever had a serious head or neck injury?	O Yes O No	If yes: ____________
Are you taking any medications, pills or drugs?	O Yes O No	If yes: ____________
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	If yes: ____________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes O No	If yes: ____________
Are you on a special diet?	O Yes O No	If yes: ____________
Do you use tobacco?	O Yes O No	If yes: ____________
Do you use controlled substances?	O Yes O No	If yes: ____________

Women: Are you… O Pregnant/Trying to get pregnant O Nursing O Taking oral contraceptives?

Are you allergic to any of the following?

O Aspirin	O Penicillin	O Codeine	O Acrylic
O Metal	O Latex	O Sulfa Drugs	O Local anesthetics
O Other ____________			

Do you have, or have you had, any of the following?

O AIDS/HIV Positive	O Cortisone Medicine	O Hemophilia	O Radiation Treatments
O Alzheimer's Disease	O Diabetes	O Hepatitis A	O Recent Weight Loss
O Anaphylaxis	O Drug Addiction	O Hepatitis B or C	O Renal Dialysis
O Anemia	O Easily Winded	O Herpes	O Rheumatic Fever
O Angina	O Emphysema	O High Blood Pressure	O Rheumatism
O Arthritis/Gout	O Epilepsy or Seizures	O High Cholesterol	O Scarlet Fever
O Artificial Heart Valve	O Excessive Bleeding	O Hives or Rash	O Shingles
O Artificial Joint	O Excessive Thirst	O Hypoglycemia	O Sickle Cell Disease
O Asthma	O Fainting Spells/ Dizziness	O Irregular Heartbeat	O Sinus Trouble
O Blood Disease	O Frequent Cough	O Kidney Problems	O Spina Bifida
O Blood Transfusion	O Frequent Diarrhea	O Leukemia	O Stomach/Intestinal Disease
O Breathing Problems	O Frequent Headaches	O Liver Disease	O Stroke
O Bruise Easily	O Genital Herpes	O Low Blood Pressure	O Swelling of Limbs
O Cancer	O Glaucoma	O Lung Disease	O Thyroid Disease
O Chemotherapy	O Hay Fever	O Mitral Valve Prolapse	O Tonsillitis
O Chest Pains	O Heart Attack/Failure	O Osteoporosis	O Tuberculosis
O Cold Sores/Fever Blisters	O Heart Murmur	O Pain in Jaw Joints	O Tumors or Growths
O Congenital Heart Disorder	O Heart Pacemaker	O Parathyroid Disease	O Ulcers
O Convulsions	O Heart Trouble/Disease	O Psychiatric Care	O Venereal Disease

Have you ever had any serious illness not listed? O Yes O No If yes, please explain: ____________

Comments: ____________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my children 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 behalf of my dependents. Please note, there is a 1% finance charge on all account balances over 60 days.

Signature of Patient, Parent or Guardian: ____________________ Date: ____________

LACEY – ANTHOLZ – DONNER DENTISTS, P.C.

Stuart G. Lacey, DDS **Travis J. Antholz, DDS** **Sarah C. Donner, DDS**

Name: ______________________________ Birthdate: __________ Sex: M F Date: __________
(First – Middle - Last) (Preferred name if applicable)

Address: ______________________________ City: ____________ State: ______ Zip Code: ________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Email Address: ______________________________ Social Security Number: ______________________

I prefer to be contacted via: O Home Phone O Cell Phone O Work Phone O Email O Text
(Please check all that apply)

Please circle the appropriate status: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

Patient's Employer: ______________________________ Position: ______________________

Spouse: ______________________ Employer: ________________ Phone: ______________

PLEASE COMPLETE THE NEXT SECTION IF PATIENT IS A MINOR CHILD OR STUDENT LIVING AWAY FROM HOME

Minor child living with: Mother Father Both Other: ________ Student Status/School: ______________
(Circle one)

Mother's Name: ______________________ DOB: ____________ SS#: ______________

Employer: ______________________ Work Phone: ______________

Father's Name: ______________________ DOB: ____________ SS#: ______________

Employer: ______________________ Work Phone: ______________

RESPONSIBLE PARTY

Name of person responsible for this account: ______________________________

Billing Address: ______________________________

DENTAL INSURANCE INFORMATION

Please provide us with a copy of your dental insurance card

Primary Carrier: ______________________________ Employer: ______________________

Policyholder: ________________ Policy #: ________________ Group #: ________________

Secondary Carrier: ______________________________ Employer: ______________________

Policyholder: ________________ Policy #: ________________ Group #: ________________

Nearest relative or friend NOT living in the same household:

Name: ______________________________ Relationship: ______________________

Address: ________________ Home Phone: ________________ Work Phone: ______________