LINCOLN DENTAL CARE

CONFIDENTIAL PATIENT HEALTH RECORD #_____

NAME: _____ Male ❑ Female ❑ D.O.B._____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip)

SS#:_____/____/_____ Home Phone ____-_____-_____ Cell Phone ____-_____-_____ Work Phone ____-_____-_____

RESPONSIBLE PARTY: _____ Relationship to Patient:_____

D.O.B.: _____ SS# _____/____/_____ Home Phone ____-_____-_____ Work Phone ____-_____-_____

Address _____
If different from patient

Your E-Mail Address_____ Referred By: _____

MEDICAL HEALTH

General health (please check): EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑ Last complete physical _____
Name and address of physician _____ Phone: _____
Are you taking any medication now? Yes ❑ No ❑ For what purpose? _____
Which medications? _____
Do you require antibiotics before routine dental treatment? Yes ❑ No ❑ Why? _____
Are you allergic to: Antibiotics ❑ Codeine ❑ Local anesthetics ❑ Latex ❑ Other _____

Anemia . . . . . Y ❑ N ❑	Headaches . . . . . Y ❑ N ❑	Multiple sclerosis . . . . . Y ❑ N ❑
Aspirin daily . . . . . Y ❑ N ❑	Heart murmur . . . . . Y ❑ N ❑	Nervous system irritability Y ❑ N ❑
Arteriosclerosis. . . . . Y ❑ N ❑	Heart disorders . . . . . Y ❑ N ❑	Neuralgia . . . . . Y ❑ N ❑
Autoimmune disorders . . . Y ❑ N ❑	Heart pacemaker . . . . . Y ❑ N ❑	Osteoporosis medication . Y ❑ N ❑
Bleeding easily. . . . . Y ❑ N ❑	Heart valve replacement . Y ❑ N ❑	Osteoarthritis . . . . . Y ❑ N ❑
Bleeding disorders . . . . . Y ❑ N ❑	Hemophilia . . . . . Y ❑ N ❑	Parkinson's disease . . . . Y ❑ N ❑
Cancer . . . . . Y ❑ N ❑	Hepatitis . . . . . Y ❑ N ❑	Prolonged bleeding . . . . . Y ❑ N ❑
Chemotherapy . . . . . Y ❑ N ❑	High/Low blood pressure Y ❑ N ❑	Psychiatric care . . . . . Y ❑ N ❑
Chronic mouth dryness . . Y ❑ N ❑	Hypoglycemia . . . . . Y ❑ N ❑	Radiation Therapy . . . . . Y ❑ N ❑
Colitis/stomach troubles . . Y ❑ N ❑	Injury to head or neck . . . Y ❑ N ❑	Rheumatic fever . . . . . Y ❑ N ❑
Current pregnancy . . . . . Y ❑ N ❑	Insomnia . . . . . Y ❑ N ❑	Sickle Cell Anemia . . . . . Y ❑ N ❑
Depression. . . . . Y ❑ N ❑	Contagious disease . . . . . Y ❑ N ❑	Sinus problems . . . . . Y ❑ N ❑
Diabetes . . . . . Y ❑ N ❑	Jaw joint surgery . . . . . Y ❑ N ❑	Stroke/Heart attack . . . . . Y ❑ N ❑
Epilepsy/Convulsions . . . Y ❑ N ❑	Joint replacement . . . . . Y ❑ N ❑	Thyroid problems . . . . . Y ❑ N ❑
Fainting spells . . . . . Y ❑ N ❑	Kidney problems . . . . . Y ❑ N ❑	Tuberculosis/lung disease Y ❑ N ❑
Glaucoma. . . . . Y ❑ N ❑	Liver disease . . . . . Y ❑ N ❑	Other Medical history . . . Y ❑ N ❑

Add anything you feel important: _____

INFORMED CONSENT

1. I am responsible for ALL charges related to services provided to me at the usual and customary charges of the dental office.
2. I hereby grant authority to the dentist(s) in charge of my care to administer treatment, anesthetics or drugs and to perform such operations as may be deemed necessary in the diagnosis and treatment of my case. I acknowledge that I have been informed of the risks, benefits, alternatives and possible consequences of the treatment proposed and I authorize the treatment.
4. Dental treatment may include examination, X-rays, cleaning, gum disease treatment, fillings, root canals and prosthodontics usually with local anesthesia. If the cavity in the tooth is very deep, the removal of the nerve or the tooth may be necessary. We would like to provide you with complete information regarding the risks and benefits of your dental treatment.
3. I was provided with THE DENTAL MATERIALS FACT SHEET as required by California Law. I also understand that The Fact Sheet would be provided to me anytime in the future upon my request.

Signed X _____ Date _____
Signature of Patient or Parent if minor

(Continue other side)

DENTAL HEALTH

Reason for visit: _____ When was your last dental visit? _____

Prior dentist name: _____ What was last treatment? _____

Have you ever had any serious medical problem associated with previous dental treatment? Yes ❑ No ❑

If so, explain: _____

How often do you brush your teeth? _____times /day. ◆ Smoke tobacco? ❑ N ❑ Y _____ cigarettes /day

What texture brush do you use? ❑ SOFT ❑ MEDIUM ❑ HARD

Do you floss daily? Yes ❑ No ❑ Do your gums bleed when brushing or flossing? Yes ❑ No ❑

Do you feel pain when your teeth come in contact with: ❑ Hot ❑ Cold ❑ Sweets ◆ Gagging easily? ❑ Yes ❑ No

Do you chew on only one side of your mouth? Yes ❑ No ❑ If yes, explain:_____

Do your gums feel tender or swollen? Yes ❑ No ❑ Do you clench or grind your jaws while sleeping or during the day? Yes ❑ No ❑

Do your jaws ever feel tired? Yes ❑ No ❑ ◆ Do your jaws "pop" or "click"? Yes ❑ No ❑ ◆ Facial pain? ❑ Yes ❑ No

Numbness in lower lip or jawbone ❑ Yes ❑ No ◆ Would you like to change anything about your smile? Yes ❑ No ❑

Explain:_____

Do you feel your oral condition is affecting your general health in any way? _____

_____

Please add anything you feel is important: _____

_____

INSURANCE INFORMATION

Name of Insured _____ Relationship to patient_____

Employer _____ Address_____Work Phone _____

Insurance Company _____ GROUP# _____Policy # _____

Additional Insurance Yes ❑ No ❑ Insured's SS#:_____/____/_____

Name of Insured _____ Relationship to patient_____

Employer _____ Address_____Work Phone _____

Insurance Company _____ GROUP# _____Policy # _____

If patient is a student, Name of School/College_____

I, the undersigned, hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the Dental Provider, of insurance benefits under which I am entitled. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

_____ X _____

DATE SIGNED

ANNUAL MEDICAL HISTORY UPDATES

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health information has changed as follows (if no change, write "NO CHANGE"): _____

_____

X_____ _____ _____

Signature of Patient (or Guardian) Date Update reviewed by Dr.

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health information has changed as follows (if no change, write "NO CHANGE"): _____

_____

X_____ _____ _____

Signature of Patient (or Guardian) Date Update reviewed by Dr.

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health information has changed as follows (if no change, write "NO CHANGE"): _____

_____

X_____ _____ _____

Signature of Patient (or Guardian) Date Update reviewed by Dr.