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WELCOME!
It is a pleasure to serve you! Please fill out the front and back completely. The better we communicate, the better we can help you. If you have any questions, please ask.

PATIENT INFORMATION

NAME ______________________________

PREFERRED NAME ______________________________

☐ MALE ☐ FEMALE

BIRTHDATE ____/____/____ AGE __________

SS#______ -________ -________ DL # and State: ______________

ADDRESS ______________________________

____

EMAIL ADDRESS ______________________________

HOME # _________________ WORK # _________________

CELL #______________________________

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

EMPLOYER NAME: ______________________________

HOW DID YOU HEAR ABOUT US?__________________________

RESPONSIBLE PARTY INFORMATION

NAME ______________________________

PREFERRED NAME ______________________________

☐ MALE ☐ FEMALE

BIRTHDATE ____/____/____ AGE __________

SS#______ -________ -________ DL # and State: ______________

ADDRESS ______________________________

____

EMAIL ADDRESS ______________________________

Please provide two phone numbers

HOME # _________________ WORK # _________________

CELL #______________________________

EMPLOYER NAME: ______________________________

RELATIONSHIP TO PATIENT? __________________________

MEDICAL INFORMATION

Current Primary Physician: ______________________________ Phone #______________________________

Please check if you have currently or have been treated for any of the following diseases or conditions?

☐ Abnormal bleeding/Hemophilia ☐ Anemia ☐ Arthritis ☐ Asthma or Hayfever ☐ Bone Disorders
☐ Congenital Heart Defect ☐ Diabetes ☐ Dizziness ☐ Epilepsy ☐ Gastrointestinal Disorders ☐ Heart Problems
☐ Heart Murmur ☐ Hepatitis/Liver Problems ☐ Herpes ☐ High Blood Pressure ☐ HIV/Aids ☐ Pneumonia
☐ Kidney Disease ☐ Nervous Disorders ☐ Prolonged Bleeding ☐ Radiation/Chemotherapy ☐ Rheumatic Fever
☐ Tuberculosis ☐ Tumor or Cancer ☐ Pacemaker ☐ Endocrine Problems ☐ Glaucoma ☐ COPD ☐ Mental Disorders
☐ Smoker ☐ Alzheimer's

Please list any other medical conditions or operation you currently have or had in the past:

Please list any medications that you are currently taking:

Please check if you are allergic to any of the following:

☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Erythromycin ☐ Sulfa ☐ Iodine ☐ Dental Anesthetics ☐ Latex

Please list any other allergies: ______________________________

Do you smoke or chew tobacco? _ YES _ NO Do you have diabetes? _ Yes _ No Do you have a family history of periodontal disease? _ Yes _ No

Women: Are you pregnant? _ YES _ NO Due date: ______________ Are you nursing? _ YES _ NO

Do you need to be premedicated for Mitral Valve Prolapse, Heart Murmur, or any kind ofjoint/bone/valve replacement? _ Yes _ No

DENTAL INFORMATION

Previous Dentist: ___________________________ **City/State:** ____________________

Last Dental Visit: __________________________ **How often do you brush?** _____________ **How often do you floss?**______

Please check if you have any of the following conditions or symptoms?
☐ clench/grind teeth ☐ jaw discomfort ☐ bleeding gums ☐ teeth sensitive to pressure ☐ teeth sensitive to hot
☐ teeth sensitive to cold ☐ teeth sensitive to sweets ☐ cracks in teeth ☐ dental pain where?____________________

Please tell us about any other dental concerns that you may have or any information that you feel is important for us know:

Please check if you are interested in learning more about the following:
☐ whitening ☐ braces ☐ nitrous sedation (laughing gas)

Are you happy with your smile? _ YES _ NO
If no, please tell us why:

Do you have silver or discolored fillings or unnatural looking crowns or bridges that you wished looked different? YES NO
If yes, please explain:

By signing below, you agree that you understand and are in agreement with Lake Travis Family & Cosmetic Dentistry's Cancellation and Financial Policies.

___________________________________ ___________________________________
Patient/Guardian Signature **Date**

___________________________________ ___________________________________
Patient Name Printed **Date**

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices
Please Note: It is your right to refuse to sign this Acknowledgement.

_____________________________ ___________________________________ ____________
Patient/Guardian Signature **Printed Patient Name** **Date**

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other:___________________________

Office Use: Signatures Y N Contact Info Y N Dental Ins. Y N Scanned: Y N Initials _______