WELCOME TO LIFETIME DENTAL

New Patient Health History Form

PATIENT INFORMATION				
Name:		Today's Date:		
SS # :	Birthdate:	Address:		
Gender: ☐ **Male** ☐ **Female** ☐ **Other**	Age:	City:	State:	Zip:
Occupation:		☐ **Married** ☐ **Widowed** ☐ **Single** ☐ **Separated** ☐ **Divorced**		
Patient Employer/School:		Who may we thank for referring you?		
		Employer/School Address:		

CONTACT INFORMATION		INSURANCE INFORMATION
Cell # :	Home # :	I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Lifetime Dental all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date below:
Emergency Contact Name/Relation:		**Name of Insurance Company**: ___________________________
Emergency Contact #:		**Subscriber's Name**:________________ **Date**:__________________
Email Address:		**Signature of parent or responsible party**: ___________________________

DENTAL INFORMATION	
Do your gums bleed when you brush or floss? ☐ **Yes** ☐ **No**	Do you have a dry mouth? ☐ **Yes** ☐ **No**
Are your teeth sensitive to hot/cold/sweets/pressure? ☐ **Yes** ☐ **No**	Have you had any periodontal gum treatment or gum disease? ☐ **Yes** ☐ **No** If yes, date treatment was completed _________________
Have you had orthodontic (braces/Invisalign) treatment? ☐ **Yes** ☐ **No**	Do you drink bottled or filtered water? ☐ **Yes** ☐ **No**
Do you have any earaches or neck pain? ☐ **Yes** ☐ **No**	Do you have sores or ulcers in your mouth? ☐ **Yes** ☐ **No**
Have you had a serious injury to your head neck or mouth? ☐ **Yes** ☐ **No**	Do you wear dentures or partials? ☐ **Yes** ☐ **No**
Do you brux or grind your teeth? ☐ **Yes** ☐ **No**	Do you have any clicking, popping, or discomfort in the jaw? ☐ **Yes** ☐ **No**
Are you currently experiencing any dental pain or discomfort? ☐ **Yes** ☐ **No**	Have you ever had any problems associated with previous dental treatment? ☐ **Yes** ☐ **No**
Previous Dentist:	Previous Dentist Phone #:
Date of your last dental exam?	What was done at that time?
What is the reason for your visit today?	Date of last dental xrays?
How do you feel about your smile?	Any concerns to discuss today?

HEALTH HISTORY	
Are you currently under the care of a physician or are you receiving medical care	☐ **Yes** ☐ **No**
Name of your physician:	Physician phone number:
Date of your last medical visit:	

Please answer these to the best of your knowledge, we want to know this information so we can give you the best care. Your answers are confidential and for our records only

AIDS/HIV ☐ **Yes** ☐ **No**	Epilepsy/Seizure ☐ **Yes** ☐ **No**	Cancer ☐ **Yes** ☐ **No** If yes, what type ________________
Hepatitis ☐ **Yes** ☐ **No** If yes, what type__________	Fainting or Dizziness ☐ **Yes** ☐ **No**	Radiation treatment ☐ **Yes** ☐ **No**
Human Papiloma Virus (HPV) ☐ **Yes** ☐ **No**	Glaucoma ☐ **Yes** ☐ **No**	Chemotherapy ☐ **Yes** ☐ **No**
Herpes/Cold Sores ☐ **Yes** ☐ **No**	Headaches ☐ **Yes** ☐ **No**	Shortness of breath ☐ **Yes** ☐ **No**
Blood Disorders/Disease ☐ **Yes** ☐ **No** If yes, what kind________________	Heart murmur ☐ **Yes** ☐ **No**	Asthma ☐ **Yes** ☐ **No**
Arthritis ☐ **Yes** ☐ **No**	Heart problems ☐ **Yes** ☐ **No**	Emphysema ☐ **Yes** ☐ **No**
Artificial heart valves ☐ **Yes** ☐ **No**	Fibromyalgia ☐ **Yes** ☐ **No**	COPD ☐ **Yes** ☐ **No**
Artificial joints ☐ **Yes** ☐ **No**	High Blood Pressure ☐ **Yes** ☐ **No**	Cough; Persistent/Bloody ☐ **Yes** ☐ **No**
Abnormal bleeding with surgery or extractions? ☐ **Yes** ☐ **No**	Low Blood pressure ☐ **Yes** ☐ **No**	Sinus trouble ☐ **Yes** ☐ **No**
Auto Immune Disorder ☐ **Yes** ☐ **No** If yes, what kind ____________?	Mitral Valve Prolapse ☐ **Yes** ☐ **No**	Stroke ☐ **Yes** ☐ **No** If yes, when? ________________
Chemical Dependency ☐ **Yes** ☐ **No**	Atrial Fibrillation ☐ **Yes** ☐ **No**	Cerebral Palsy ☐ **Yes** ☐ **No**
Circulatory problems ☐ **Yes** ☐ **No**	Pacemaker ☐ **Yes** ☐ **No**	Thyroid Problems ☐ **Yes** ☐ **No**
Swollen Feet/Ankles ☐ **Yes** ☐ **No**	Psychiatric care ☐ **Yes** ☐ **No**	Tonsilitis ☐ **Yes** ☐ **No**
Diabetes ☐ **Yes** ☐ **No** If yes, Most recent HbA1c? _________	Shingles ☐ **Yes** ☐ **No**	Tuberculosis (TB) ☐ **Yes** ☐ **No**
Kidney Disease ☐ **Yes** ☐ **No**	Acid Reflux/GERD ☐ **Yes** ☐ **No**	Osteoporosis ☐ **Yes** ☐ **No** If yes, are you taking medications? ☐ **Yes** ☐ **No**
Liver Disease ☐ **Yes** ☐ **No**	Parkinsons ☐ **Yes** ☐ **No**	Dementia/Alzheimer's ☐ **Yes** ☐ **No**
Cystic Fibrosis ☐ **Yes** ☐ **No**	Digestive Disorder(s) ☐ **Yes** ☐ **No** If yes, what? ______________	Sleep Apnea ☐ **Yes** ☐ **No**
Smoking/Vape ☐ **Yes** ☐ **No**	Skin Rash ☐ **Yes** ☐ **No**	

WOMEN ONLY	
Are you pregnant? ☐ **Yes** ☐ **No**	Due Date:
Are you on birth control? ☐ **Yes** ☐ **No**	Are you nursing? ☐ **Yes** ☐ **No**

MEDICATIONS	**ALLERGIES**
Are you taking any medications? (Including Prescription & Over-the-Counter)	☐ **Aspirin** ☐ **Penicillin**
	☐ **Codeine** ☐ **Latex**
	☐ **Local Anesthetic** ☐ **Sulfa**
	☐ **Other** ____________
Pharmacy Name and Number:	☐ **None**

I attest that I have, to the best of my knowledge, completed this form accurately.

Signature Relationship to Patient Date