Legacy DENTAL GROUP
Family and Cosmetic Dental Center

"Where Family is First"

Patient Information

Date _____ SS# _____

Driver's License #_____

Patient _____

Address _____

_____

City State Zip

Sex: ☐M ☐F Age_____ Birthdate _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Occupation _____

Employer _____

Employer Address _____

Employer Phone (_____)_____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

Dental Insurance

Who is responsible for this account?_____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name _____

Birthdate _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Phone Numbers

Home (_____)_____ Work (_____)_____ Ext _____ Spouse's Work (_____)_____

Cell Phone (_____)_____ E-Mail_____ Spouse's Cell Ph. (_____)_____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship_____

Home Phone (_____)_____ Work Phone (_____)_____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate If you have had any of the following:

Bad Breath	☐Yes	☐No
Bleeding gums	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No
Chew on one side of mouth	☐Yes	☐No
Cigarette, pipe, or cigar smoking	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No
Dry mouth	☐Yes	☐No
Fingernail biting	☐Yes	☐No
Food collection between the teeth	☐Yes	☐No
Foreign objects	☐Yes	☐No
Grinding teeth	☐Yes	☐No
Gums swollen or tender	☐Yes	☐No
Jaw pain or tiredness	☐Yes	☐No
Lip or cheek biting	☐Yes	☐No
Loose teeth or broken fillings	☐Yes	☐No
Mouth Breathing	☐Yes	☐No
Mouth pain, brushing	☐Yes	☐No
Orthodontic treatment	☐Yes	☐No
Pain around ear	☐Yes	☐No
Peridontal treatment	☐Yes	☐No
Sensitivity to cold	☐Yes	☐No
Sensitivity to heat	☐Yes	☐No
Sensitivity to sweets	☐Yes	☐No
Sensitivity when biting	☐Yes	☐No
Sores or growths in your mouth	☐Yes	☐No

How often do you floss? _____

How often do you brush?_____

Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ○ Yes ○ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	○Yes ○No	Emphysema	○Yes ○No	Radiation Treatment	○Yes ○No
Anemia	○Yes ○No	Epilepsy	○Yes ○No	Respiratory Disease	○Yes ○No
Athritis, Rheumatism	○Yes ○No	Fainting or Dizziness	○Yes ○No	Rheumatic Fever	○Yes ○No
Artificial Heart Valves	○Yes ○No	Glaucoma	○Yes ○No	Scarlet Fever	○Yes ○No
Artificial Joints	○Yes ○No	Headaches	○Yes ○No	Shortness of Breath	○Yes ○No
Asthma	○Yes ○No	Heart Murmur	○Yes ○No	Sinus Trouble	○Yes ○No
Back Problems	○Yes ○No	Heart Problems	○Yes ○No	Skin Rash	○Yes ○No
Bleeding abnormally, with extractions or surgery	○Yes ○No	Hepatitis Type --Select One--	○Yes ○No	Special Diet	○Yes ○No
		Herpes	○Yes ○No	Stroke	○Yes ○No
Blood Disease	○Yes ○No	High Blood Pressure	○Yes ○No	Swollen Feet or Ankles	○Yes ○No
Cancer	○Yes ○No	Jaundice	○Yes ○No	Swollen Neck Glands	○Yes ○No
Chemical Dependency	○Yes ○No	Jaw Pain	○Yes ○No	Thyroid Problems	○Yes ○No
Chemotherapy	○Yes ○No	Kidney Disease	○Yes ○No	Tonsillitis	○Yes ○No
Circulatory Problems	○Yes ○No	Liver Disease	○Yes ○No	Tuberculosis	○Yes ○No
Congenital Heart Lesions	○Yes ○No	Low Blood Pressure	○Yes ○No	Tumor or growth on head or neck	○Yes ○No
Cortisone Treatments	○Yes ○No	Mitral Valve Prolapse	○Yes ○No		
Cough, persistent or bloody	□Yes □No ○Yes ○No	Nervous Problems	○Yes ○No	Ulcer	○Yes ○No
		Pacemaker	○Yes ○No	Venereal Disease	○Yes ○No
Diabetes	○Yes ○No	Psychiatric Care	○Yes ○No	Weight Loss, unexplained	○Yes ○No

Do you wear contact lenses? ○ Yes ○ No

Women:

Are you pregnant? ○Yes ○ No Due date _____ Are you nursing? ○ Yes ○ No

Taking birth control pills? ○Yes ○No

Medications

List any medications you are taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____)_____

Allergies

- ☐ Aspirin
- ☐ Barbituates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex _____
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

_____

Updates (To be filled in at future appointments)

Has there been any change in you health since your last appointment? ○ Yes ○ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Has there been any change in your health since your last dental appointment? ○ Yes ○ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Submit