# LWSS Family Dentistry, Ltd
## Orthodontics & Dentistry For Children

lwssfamilydentistry.com

**PERSONAL, MEDICAL AND DENTAL HISTORY**

We are continually concerned with your health and the care that is rendered to you. It is therefore important to update this information every 2 years . If you have any questions, please feel free to ask one of our staff members to assist you. Please print clearly.

## PATIENT INFORMATION

Date ______________________________________________

Patient ____________________________________________
First M.I. Last

Address ___________________________________________

___________________________________________________
City State Zip

Sex: ☐ M ☐ F Age _______ Birthdate _____________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _______________________________________

Occupation or Student _______________________________

Employer or School Name _____________________________

Employer Street Address ______________________________

___________________________________________________
City State Zip

Employer Phone ________________________Ext. __________

Spouse's Name ______________________________________

Birthdate ________________ SS# ______________________

0ccupation ________________________________________

Spouse's Employer ___________________________________

Whom may we thank for referring you?____________________

___________________________________________________

## DENTAL INSURANCE

Subscriber Name ____________________________________

ID# ______________________________________________

Insurance Co. _______________________________________

Group # ___________________________________________

Is Patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ___________________________________

Birthdate ________________ SS# ______________________

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 LWSS Family Dentistry, LTD 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 ____________________________ Cell _________________________ Spouse's Work ______________________________

Email ______________________________________________________________________________________________

**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 visit __________________

Date of last dental X-Rays___________

Are you happy with your smile?_______

Interested in learning about tooth whitening? _____________

Place a mark on "Yes" or "No" to indicate if you have had the following:

Bad Breath ☐ Yes ☐ No
Bleeding Gums ☐ Yes ☐ No

Blister 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
Food collection between the teeth ☐ 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
Periodontal treatment ☐ Yes ☐ No
Sensitivity to cold ☐ 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_ _____________

## CONSENT

I give permission to release treatment (past and future), payments and insurance activity to the following:

Name ______________________________________________________ Relationship ___________________________________

Name ______________________________________________________ Relationship ___________________________________

I ______________________________________, have had full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that by signing this section, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities and health care operations.

Signature ________________________________________________

## HEALTH HISTORY

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

| Condition | Yes | No |
|---|---|---|
| AIDS | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No |
| Arthritis, Rheumatism | ☐ Yes | ☐ No |
| Artificial Heart Valves | ☐ Yes | ☐ No |
| Artificial Joints | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |
| Back Problems | ☐ Yes | ☐ No |
| Bleeding Abnormally, with extractions or surgery | ☐ Yes | ☐ No |
| Blood Disease | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No |
| Chemotherapy | ☐ Yes | ☐ No |
| Circulatory Problems | ☐ Yes | ☐ No |
| Congenital Heart Lesions | ☐ Yes | ☐ No |
| Cortisone Treatments | ☐ Yes | ☐ No |
| Cough, persistent or bloody | ☐ Yes | ☐ No |
| Deaf | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Emphysema | ☐ Yes | ☐ No |
| Epilepsy | ☐ Yes | ☐ No |
| Fainting or dizziness | ☐ Yes | ☐ No |
| Glaucoma | ☐ Yes | ☐ No |
| Headaches | ☐ Yes | ☐ No |
| Hearing Impaired | ☐ Yes | ☐ No |
| Heart Murmur | ☐ Yes | ☐ No |
| Heart Problems | ☐ Yes | ☐ No |
| Hepatitis Type _________ | ☐ Yes | ☐ No |
| Herpes | ☐ Yes | ☐ No |
| High Blood Pressure | ☐ Yes | ☐ No |
| HIV Positive | ☐ Yes | ☐ No |
| Jaundice | ☐ Yes | ☐ No |
| Jaw Pain | ☐ Yes | ☐ No |
| Kidney Disease | ☐ Yes | ☐ No |
| Liver Disease | ☐ Yes | ☐ No |
| Low Blood Pressure | ☐ Yes | ☐ No |
| Mitral Valve Prolapse | ☐ Yes | ☐ No |
| Nervous Problems | ☐ Yes | ☐ No |
| Pacemaker | ☐ Yes | ☐ No |
| Psychiatric Care | ☐ Yes | ☐ No |
| Radiation Treatment | ☐ Yes | ☐ No |
| Respiratory Disease | ☐ Yes | ☐ No |
| Rheumatic Fever | ☐ Yes | ☐ No |
| Scarlet Fever | ☐ Yes | ☐ No |
| Shortness of Breath | ☐ Yes | ☐ No |
| Sinus Trouble | ☐ Yes | ☐ No |
| Skin Rash | ☐ Yes | ☐ No |
| STD's | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No |
| Swelling of Feet or Ankles | ☐ Yes | ☐ No |
| Swollen Neck Glands | ☐ Yes | ☐ No |
| Thyroid Problems | ☐ Yes | ☐ No |
| Tonsillitis | ☐ Yes | ☐ No |
| Tuberculosis | ☐ Yes | ☐ No |
| Tumor or growth on head or neck | ☐ Yes | ☐ No |
| Ulcer | ☐ Yes | ☐ No |
| Weight Loss, unexplained | ☐ Yes | ☐ No |
| Other medical condition we should be aware of | ☐ Yes | ☐ No |
| Women: Are you pregnant? Due date _________ | ☐ Yes | ☐ No |
| Are you nursing? | ☐ Yes | ☐ No |

## MEDICATIONS

List medications you are currently taking:

____________________________________________________

Pharmacy Name ______________________________________

Phone ______________________________________________

Physician's Name ____________________________________

Phone ______________________________________________

## ALLERGIES

☐ Aspirin
☐ Local Anesthetic
☐ Barbiturates (Sleeping Pills)
☐ Penicillin
☐ Codeine
☐ Sulfa
☐ Iodine
☐ Other _______________
☐ Latex ____________________________________________

**FINANCIAL ARRANGEMENTS:** Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment:

Cash   Personal Check   Charge Cards

I hereby apply for treatment by the above dentists, their associates and/or assistants. Treatment may include x-rays, injections and/or such other office procedures they deem necessary.

If health care workers are accidently exposed to my blood or body fluids in the course of providing health care to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

Payment policies of LWSS Family Dentistry have been explained to me, and I hereby acknowledge and accept responsibility for payment of all charges incurred with the above dentists, acknowledging that they may obtain a credit report in order to establish credit.

It is understood that this responsibility extends to the total charges without regard to possible insurance benefits, and that any insurance benefits which may be provided will be considered part of my financial resource only and will not waive my responsibility. If payment for such medical services is not made when due, the undersigned agrees to pay all costs of collecting the medical bill, including 33⅓% attorneys' fees and costs, skip tracing and third party services. I have read and fully understand the meaning and consequences of the above statement. INTEREST RATE: 1½ % PER MONTH (Equivalent 18% APR) on that part of accounts due over 60 days (Minimum interest rate $.50}.

PATIENTS WITHOUT INSURANCE - PAYMENT IS DUE AT THE TIME OF THE VISIT

**A charge of $25.00 will be made for appointments broken or cancelled without 24 hour notice**. A charge of $25.00 will be made for returned checks. CareCredit will be accepted if the total due from the patient is $250.00 or over at each appointment and there is no insurance adjustment or courtesy. The patient's CareCredit balance will be verified before each appointment.

PATIENT ______________________________ RESPONSIBLE PARTY ________________________________

DATE ________________________________________