WELCOME

Gregg L. Lage, DDS

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (_____) _____ Cell #: _____

Wk #: (_____) _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Dentist Phone: _____ Last Visit Date _____

2 SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Wk #: (_____) _____ Ext: _____ SS #: _____

Birthdate: ____/____/____ DL #: _____

Person Responsible for Account: _____

Wk #: (_____) _____ Ext: _____ Hm #: (_____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____

Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Neighbor or Relative not living with you.

Their Name: _____ Relation: _____

Wk #: (_____) _____ Hm #: (_____) _____

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (_____) _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

_____

Dental History

Why have you come to the dentist today?_____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold; anything else?_____

Do you have mobility in your teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Previous/Present Dentist:_____ Last Visit Date:_____
(Please Circle)

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change?_____

_____

Medical History

Are you currently taking any of the following?

Y N Acetaminophen	Y N Blood Pressure Medication	Y N Recreational Drugs
Y N Antibiotics	Y N Cold Remedies	Y N Steroids/Cortisone
Y N Antihistamines	Y N Digitalis/Heart Medication	Y N Thyroid Medicine
Y N Aspirin	Y N Insulin/Diabetes Drugs	Y N Tranquilizers
Y N Blood Thinners	Y N Nitroglycerin	

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain:_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Phen-Fen, Redux or Pondimin? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week #:_____ Are you nursing? ☐ Yes ☐ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV + /AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced:_____

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No If yes, please list each one:_____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry/Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reaction:_____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

I have received a copy of this office's Notice of Privacy Practices.

_____
Signature Date

Medical History Update

I have read my medical history dated_____ and confirmed that it states past and present medical condition_____

Signature Date

I have read my medical history dated_____ and confirmed that it states past and present medical condition_____

Signature Date

