James B. Lewis
D.M.D., P.A.
GENERAL AND ADVANCED
RESTORATIVE DENTISTRY

METHOD OF PAYMENT

Responsible party currently has an account with this office

☐ Yes ☐ No

☐ Payment in full at each appointment (cash or personal check)

☐ Payment in full at each appointment (☐ VISA p MC p OTHER)

Card #_____ Exp Date_____

☐ I wish to discuss the Dental Office's Financial Policy

PATIENT REGISTRATION

Patient Information

First Name: _____ M.I.: _____ Last Name: _____

I prefer to be called: _____

Address: _____

City: _____ State / Zip: _____

Home Phone: _____ Work Phone: _____ ext. _____ Cell Phone: _____

Sex: ❍ Male ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____

Referred By: _____ Emergency Contact & Phone #: _____

Last Dental Visit: _____ Former Dentist: _____

I am: ❍ Insurance Policyholder ❍ Responsible Party for this account

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Employer: _____

Home Phone: _____ Work Phone: _____ ext. _____ Cell Phone: _____

Birth Date: _____ Soc. Sec: _____

❍ Responsible Party is also a Policy Holder for Patient ❍ Primary Insurance Policy Holder ❍ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ❍ Self ❍ Spouse ❍ Child ❍ Other

Employer: _____ Employer Address: _____

Employer City, State, Zip: _____ Employer Address 2: _____

Ins. Company: _____ Ins. Co. Address: _____

Ins. Co. Phone #: _____ Ins. Co. ID#: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ❍ Self ❍ Spouse ❍ Child ❍ Other

Employer: _____ Employer Address: _____

Employer City, State, Zip: _____ Employer Address 2: _____

Ins. Company: _____ Ins. Co. Address: _____

Ins. Co. Phone #: _____ Ins. Co. ID#: _____

MEDICAL HISTORY

PATIENT NAME: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have and important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No ○ N/A _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No ○ N/A _____

Have you ever had a serious head or neck injury? ○ Yes ○ No ○ N/A _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No ○ N/A _____

Please list any over the counter herbal or other supplements you take: _____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No ○ N/A Do you use tobacco? ○ Yes ○ No ○ N/A

Are you on a special diet? ○ Yes ○ No ○ N/A Do you use controlled substances? ○ Yes ○ No ○ N/A

Women: Are you ❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Sulfa ❑ Other _____

Do you have, or have you had, any of the following?

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve*
- ❑ Artificial Joint*
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Cancer
  - Type _____
- ❑ Chemotherapy
  - Dates _____
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur*
- ❑ Heart Pace Maker*
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse*
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
  - Dates _____
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever*
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice
- ❑ Jaw Pain
- ❑ Neck Pain
- ❑ Shoulder Pain

Have you ever had any serious illness not listed above? ○ Yes ○ No ○ N/A _____

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

UPDATES (To be filled in at future appointments)

Have there been any changes in your health since your last dental appointment? ○ Yes ○ No

For what conditions? _____

Are you taking any new medications? ○ Yes ○ No If so, what? _____

Patient Signature _____ Date _____

Doctor's Signature _____ Date _____

Have there been any changes in your health since your last dental appointment? ○ Yes ○ No

For what conditions? _____

Are you taking any new medications? ○ Yes ○ No If so, what? _____

Patient Signature _____ Date _____

Doctor's Signature _____ Date _____