

PATIENT INFORMATION FORM

WELCOME!

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

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Address _____ apt./unit/ste _____

City _____ State _____ Zip _____

Home# _____ Work# _____ Mobile# _____

Birthdate / / SS# _____ Drivers Lic. _____

I would like to receive correspondences via e-mail Email Address _____

RESPONSIBLE PARTY (If someone other than the patient)

First Name _____ Middle Initial _____ Last Name _____

Address _____ apt./unit/ste _____

City _____ State _____ Zip _____

Home# _____ Work# _____ Mobile# _____

Birthdate / / SS# _____ Drivers Lic. _____

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

REFERRED BY: _____

EMERGENCY CONTACT:

Contact Name _____ Phone# _____

Relationship _____

PATIENT INFORMATION FORM

2 EMPLOYMENT

Employment Status Full Time Part Time Retired

Student Status Full Time Part Time Retired

Employer _____ School Name _____

3 INSURANCE

PRIMARY INSURANCE

Name of Insured _____

Relationship to Insured Self Spouse Child Other

Insured SS# or ID _____

Birth Date _____

Address _____

Insurance Co. _____

City _____

Insurance Phone Number _____

State _____ Zip _____

Employer _____

4 MEDICAL HISTORY

Are you under a physician's care now?

Yes No If Yes, please explain _____

Have you ever been hospitalized or had a major operation?

Yes No If Yes, please explain _____

Have you ever had a serious head or neck injury?

Yes No If Yes, please explain _____

Are you taking any medications, pills, or drugs?

Yes No If Yes, please explain _____

Do you take, or have you taken, Phen-Fen or Redux?

Yes No If Yes, please explain _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

Yes No If Yes, please explain _____

Are you on a special diet?

Yes No If Yes, please explain _____

Do you use tobacco?

Yes No

Do you use controlled substances?

Yes No

FOR WOMEN

Pregnant / Trying to get pregnant?

Yes No

Nursing?

Yes No

Taking oral contraceptives?

Yes No

If yes, _____

PATIENT INFORMATION FORM

ALLERGIES

Are you allergic to any of the following:

- Aspirin
 Penicillin
 Codeine
 Local Anesthetics
 Acrylic
 Metal
 Latex
 Sulfa Drugs
 OTHER, Explain _____

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

- | | | | |
|--|---|---|--|
| AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No
Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pace Maker <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No
Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No
High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No
Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No
Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No
Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No
Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No
Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No
Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No
Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Spinal Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|---|---|--|

Have you ever had any serious illness not listed above:

- Yes No If Yes, please explain _____

COMMENTS: _____

PATIENT INFORMATION FORM

5 MEDICAL INFO

Do you have a personal physician? Yes No

Physician's Name _____

Phone# _____ Last Visit Date / /

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

If yes, please explain: _____

Preferred Pharmacy: _____

Pharmacy Phone #: _____

7 DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges incurred is not made, I agree to pay off all costs of collection including a 50% collection fee, attorney fees and court costs.

Signature _____

Date _____

**PAYMENT IS DUE IN FULL AT TIME OF TREATMENT
UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.**

6 DENTAL HISTORY

Why have you come to the dentist today? _____

Has your doctor told you that you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is? Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you use floss? _____

How many times a day do you brush? _____

Type of toothbrush? Manual Electric

8 PRIVACY PRACTICES

Holly Lerma, D.D.S.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, _____, understand that Dr. Lerma's Office abides by the HIPAA Law and will protect the privacy of your personal information.

Please Print Name _____

Signature _____

Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment for the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.

_____ Communication barriers prohibited us from obtaining acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgment.

_____ Other (Please Specify)

WELCOME PAGE - Q&A

WE WARMLY WELCOME YOU.

To better serve you, please take just a moment to answer the following questions. Thanks!

What is the most important thing to you about your smile and dental health? _____

Please share the following approximate dates:

Your last cleaning _____

Your last oral cancer screening _____

Your last complete x-rays _____

Your last exam _____

Who was your previous dentist?

Name: _____

City: _____ State: _____

Phone: _____

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

- Dentures
- Partial Dentures
- Periodontal (gum) treatments

If you could whiten your teeth, at a cost that anyone could afford, would you like to? Yes No

Do you smoke or use chewing tobacco

- Yes No

If yes, how much? And, for how long?

If you could change your smile, would you:

(Please check all that apply)

- Have a bright white smile
- Make your teeth straighter
- Close spaces between teeth
- Replace silver metal fillings with tooth-colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover
- Healthy gums
- Fresh breath

On a scale of 1 to 5, with 5 being the highest rating:

(Please circle the number that best applies)

How important is your dental health to you?

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where do you want your dental health care to be?

1 2 3 4 5

Why did you leave your previous dentist? _____

What is the most important thing to you about your dental visit today? _____

THANK YOU!

We appreciate you for filling out this form completely.

It will allow us to serve you more effectively.

If you have a question at any time, please call us. [We are happy to help.](#)