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DATE_______________
(MO) (DAY) (YR)

PATIENT'S NAME____
(LAST) (FIRST) (MIDDLE INITIAL)

HOW WOULD YOU LIKE TO BE ADDRESSED IN OUR OFFICE?_______________

BIRTHDATE_______________ MALE _______ FEMALE _______
(MO) (DAY) (YR)

HOME ADDRESS ____
(STREET) (CITY) (STATE) (ZIP)

TELEPHONE NUMBER _______________ CELL PHONE NUMBER _______________

BEST NUMBER TO REACH YOU IN CASE OF SCHEDULING ISSUES _______________

EMAIL ADDRESS ____

WOULD YOU LIKE YOUR STATEEMENTS TO BE EMAILED? ❑ YES ❑ NO

MARITAL STATUS SINGLE ____ MARRIED____ WIDOWED____ SEPARATED____ DIVORCED ____

EMPLOYED BY_______________ POSITION _______________

WORK TELEPHONE NUMBER ____

NAME OF SPOUSE ____

EMPLOYED BY_______________ POSITION _______________

WORK TELEPHONE NUMBER ____

PRIMARY DENTAL INSURANCE _______________ GROUP NUMBER _______________

SUBSCRIBER'S ID NUMBER _______________ SUBSCRIBER'S BIRTHDATE _______________

SECONDARY DENTAL INSURANCE _______________ GROUP NUMBER _______________

SUBSCRIBER'S ID NUMBER _______________ SUBSCRIBER'S BIRTHDATE _______________

DO YOU HAVE STATE MEDICAL ASSISTANCE? YES _______ NO _______

WHO WILL PAY FOR THIS ACCOUNT?____

(ADDRESS, IF DIFFERENT THAN ABOVE) ____

WHOM CAN WE THANK FOR REFERRING YOU TO THIS OFFICE?_______________

A 1.5% PER MONTH CHARGE WILL APPLY TO ALL ACCOUNTS NOT PAID IN FULL WITHIN 90 DAYS OF TREATMENT

(Please continue on other side)

Patient's Name:	DOB:
List of Current Medications	**Allergies**
________ ________	❑ Aspirin ❑ Codeine ❑ Penicillin
________ ________	❑ Sulfa ❑ Clindamycin
________ ________	❑ Eggs/Yolk ❑ Latex ❑ Metal
________ ________	❑ No Known Allergies
________ ________	❑ Other:________

Pharmacy Name & Location:	Phone #:
Have you ever had any radiation to the head or neck? ❑ Yes ❑ No	If yes, facility?
Are you diabetic?	❑ Yes ❑ No
Are you on blood thinners? *Ex: Coumadin, Warfarin, Plavix, etc.*	❑ Yes ❑ No
Have you ever taken pills or injections for bone strengthening (osteoporosis)? *Ex: Fosamax, Actonel, etc.*	❑ Yes ❑ No
Do you have any artificial joints or have you had a hip/knee replacement?	❑ Yes ❑ No
Have you had a serious illness/operation in the last 2 yrs? *(hips, knees, heart, major organs)*	❑ Yes ❑ No
If Yes: Date of illness/operation ________ PRE-MED	❑ Yes ❑ No
Do you smoke, chew tobacco or vape?	❑ Yes ❑ No
Women: ❑ Pregnant ❑ Nursing	❑ Birth Control

Height:________ Weight:________

Check if you have or have had any of the following: ❑ **None** ❑ **Other:**________

❑ Anemia	❑ Fainting	❑ Pacemaker
❑ Arthritis, Rheumatism	❑ Glaucoma	❑ Poor Wound Healing
❑ Artificial Heart Valves	❑ Headaches	❑ Respiratory Disease
❑ Asthma	❑ Heart Murmur	❑ Shortness of Breath
❑ Alcohol Abuse	❑ Heart Problems	❑ Sleep Apnea
❑ Blood Disease	❑ Hemophilia	❑ Stroke
❑ Cancer	❑ Hepatitis	❑ Swelling of Feet or Ankles
❑ Chemotherapy	❑ High Blood Pressure	❑ Thyroid Problems
❑ Cough, Persistent	❑ HIV/AIDS	❑ Tuberculosis
❑ Drug Abuse	❑ Kidney Disease	❑ Treatment for Anxiety/Depression
❑ Epilepsy	❑ Liver Disease	❑ Nauseated from IV Anesthesia

Authorize Privacy Practice Notice

I hereby acknowledge that a copy of Ledgeview Dental Care's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask questions I may have regarding this Notice.

Patient/Parent(Guardian) Initials:________

Authorization to Release All information to:________ **Relationship:** ________

I understand that by initialing below I am confirming the use and disclosure of my protected health information to the authorized person(s) listed above. Authorization is good until I choose to revoke it.

Patient/Parent(Guardian) Initials:________ ❑**DECLINE RELEASE OF MY INFORMATION**

I hereby confirm that the above facts are true to the best of my knowledge:

Signature: ________ **Date:**________