LEXINGTON SMILES

Patient Information

Today's date: _____

Last name _____ First name _____ Middle initial ___

Date of Birth: _____ Gender: Male / Female Marital Status: _____

Address: (street, city, state) _____

Phone Numbers: (home)_____ (cell) _____ (work) _____

Email Address: _____ May we send reminders? Yes / No

Social Security Number: _____

Emergency Contact (or Guardian) Relationship: _____Phone Number: _____

Patient Employer:_____ Phone Number: _____

Primary Dental Insurance

Subscriber name: _____Relationship to subscriber: Self / spouse / child

Subscriber's Employer: _____ Insurance Carrier: _____

Subscriber ID: _____ Subscriber's SSN: _____

Secondary Dental Insurance

Subscriber name: _____Relationship to subscriber: Self / spouse / child

Subscriber's Employer: _____ Insurance Carrier: _____

Subscriber ID: _____ Subscriber's SSN: _____

Dental History

Previous Dentist _____ Phone Number: _____ City/State: _____

Date of last x rays taken: _____

Dental concerns: _____

Medical

Primary Care Physician: _____ Phone Number: _____

Have you had any joint replacements: Yes / No If yes, What year? _____

Do you have an artificial heart valve? Yes / No

Have you had a previous case of Infective Endocarditis? Yes / No

Do you have Congenital Heart Disease? Yes / No

Do you have a history or are you currently being treated with IV bisphosphonates? Yes / N

Please circle the following:

High Blood Pressure: Yes / No

Low Blood Pressure: Yes / No

Asthma / COPD: Yes / No

Bleeding disorders: Yes / No

Kidney Disease: Yes / No

Liver Disease: Yes / No

Diabetes: Yes / No

Hepatitis: Yes / No

Autoimmune Disorders: Yes /No

Osteoporosis: Yes / No

Aids / HIV: Yes / No

Cancer: Yes / No

Radiation Treatments: Yes / No

Heart Attack: Yes / No

STDs: Yes / No

Neurological Disorders: Yes / No

Congestive Heart Failure: Yes / No

Chronic Pain: Yes / No

Blood Transfusion: Yes / No

Thyroid Problems: Yes / No

Depression / Anxiety: Yes / No

Please explain if you answered yes to any of the above:

_____

Please list any known allergies:

_____

Please list all current medication being taken:

_____ _____

_____ _____

_____ _____

_____ _____

I have read and understand the above and all the information on this form is accurate. I will not hold the staff at Lexington Smiles PLLC responsible for any action they do or do not take because of any errors or information I have not disclosed to them in the completion of this form.

_____ _____

Signature of patient or legal guardian Date