



Patient Information

Date _____ Referring Dentist _____
Patient Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip _____
Email _____
Home Phone _____ Cell Phone _____ Work Phone _____
Employer _____ City _____
Job Title _____
Spouse Name _____ Spouse Occupation _____
Have you or any member of your family been treated by Dr. Lavin in the past? Yes No Who? _____

Responsible Party Information *(Leave blank if patient is responsible party)*

Name of Person Responsible for This Account _____
Relationship _____ Date of Birth _____
Address _____ Phone _____
City _____ State _____ Zip _____
Employer _____ Work Phone _____

Primary Dental Insurance Information

Insurance Company _____
Insured Individual _____ Self / Spouse / Parent / Other
Social Security # or Insurance ID _____ Insured DOB _____
Employer _____ Group # _____

Dental History

Reason for Today's Visit _____
Do you have dental pain? Yes No When did your pain begin? _____
Is the pain... Increasing Decreasing Not Changing Where do you feel pain? _____
Do any or all of the following trigger your pain? Cold Heat Chewing Touch
Does your pain begin spontaneously? Yes No Does anything relieve your pain? _____
Which one of the following describes your pain? Constant Intermittent Fluctuating
How would you describe your pain? Dull Ache Throbbing Sharp Shooting
Please mark your present pain level (0 is no pain, 10 is the worst pain imaginable): 0 • • • • 5 • • • • 10
Please mark the highest level of pain you have experienced with this tooth: 0 • • • • 5 • • • • 10



Health Questionnaire

Physician Name _____

Women: Are you... Pregnant/trying to get pregnant? Taking oral contraceptives? Nursing?

Allergies: Are you allergic to any of the following? (Please check)

Latex Penicillin Sulfa Aspirin Codeine Local Anesthetics Other _____

Medical Alerts: Have you had any of the following medical procedures? (Please check)

Joint Replacement w/ Pre-Med w/out Pre-Med Joint _____ Year _____

Heart Valve Replacement Year _____

Biophosphates (Fosomax, Aredia, Boniva, Zometa, Aclasta, Bonfos, Didronel, Reclast, Skelid) Osteoporosis Chemotherapy

Medical History: Do you have, or have you had any of the following? (Please check)

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

Please describe any problems not listed above: _____

Medications: Are you currently taking any of the following medications? (Please check) Antibiotics Anticoagulants

Antihistamines Blood Pressure Medications Pain Medications Steroids Tranquilizers

List of Medications _____

Pharmacy _____ Phone _____

To my knowledge, the answers above are correct.

With my signature, I certify that I have read and understand the financial policy (detailed on a separate sheet), agree to abide by it, and will pay today with one of the following: Check Cash Credit Card Care Credit

With my signature, I certify that I have had the opportunity to review the office's Notice of Privacy Practices.

With my signature, I certify that I have read and understand the information in the Consent for Endodontic Therapy (details on separate sheet), and I give my consent for treatment.

Signature (Patient/Guardian) _____ **Date** _____