LUKASIEWICZ & BELLAVANCE

PRINT RESET SAVE

PATIENT INFORMATION

DATE:_____

EMAIL:_____

NAME:_____ PREFERRED NAME_____

BIRTHDATE:01-01-50_____ MARRIED ○ SINGLE ○ MINOR ○ MALE ○ FEMALE ○

ADDRESS:_____ CITY_____STATE_____

SOCIAL SECURITY #_____ HOME PH#_____CELL#_____

PLACE OF EMPLOYMENT:_____WORK#_____

IF FULL TIME STUDENT, COLLEGE NAME:_____

DENTAL INSURANCE CO:_____SUBSCRIBER#_____GROUP#_____

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE?_____

WHOM MAY WE THANK FOR REFERRING YOU TO THE OFFICE?_____

FATHER (OR HUSBAND)

_____
LAST FIRST MI

_____
STREET CITY STATE ZIP

01-01-50
BIRTHDATE

_____
EMPLOYER

_____
DENTAL INSURANCE SUBCRIBER # GROUP #

MOTHER (OR WIFE)

_____
LAST FIRST MI

_____
STREET CITY STATE ZIP

01-01-50
BIRTHDATE

_____
EMPLOYER

_____
DENTAL INSURANCE SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name_____

Address_____

City/State/Zip_____

Telephone #_____

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One

○ Patient ○ Father (or Husband)

○ Guardian ○ Mother (or Wife)

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 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.

_____ _____

Patient signature (or if under 18, parent/guardian) Date

LUKASIEWICZ _BELLAVANCE LLC

Eaglesoft Medical History

PRINT RESET SAVE

Patient Name: Birth Date: 01-01-50

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 an 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	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

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 ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

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

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

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.

Signature of Patient, Parent or Guardian:

X---------- Date:

Lukasiewicz & Bellavance

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Dental History

Please help us to learn more about your dental history by answering the following questions. This series of questions is designed so that we are able to accommodate your specific dental needs.

- What did you like or dislike about your previous Dentist/Dental office?
  _____
- What is the approximate date of your last visit to the Dentist? _____

Dentist Name: _____

Please circle Yes or No to the following:

Do you feel nervous about having dental treatment:? YES NO

Have you had any trouble associated with previous dental treatment?: YES NO

Have you ever had gum treatments?: YES NO

Are you unhappy with your smile?: YES NO

Do you usually use 'novacaine' for dental treatment?: YES NO

Missed Appointment Policy

We do our best to keep the cost of your dental treatment as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us with 48 hours notice, another patient who could have been seen was not. This adds to the overall cost of care, as trained personnel and dental facilities are not being utilized.

In the event you have three (3) missed appointments, we will be unable to afford to help you as a patient, considering the time we lose each time you fail to keep an appointment.

Initials_____

HIPAA

The Health Insurance Portability and Accountability Act

I,_____, have received and reviewed a copy of this office's notice of Privacy Practices.

_____ _____ _____

Printed Name Signature Date