Lakewood Ranch Dental

PATIENT INFORMATION Patient Name:				DENTAL INSURANCE Same					
SS#:		☐ New or updated, please provide new card to front desk.							
Email:									
Address:		List any medications you are currently taking: □NONE							
/tdd1000.									
		□Mino							
☐ Married ☐ Sing	r								
Occupation:		Pregnant □Yes □No Breast Feeding □Yes □No							
Employer:		Allergies							
Spouse's Name:				□ Aspirin □ Local Anesthetic					
Home Phone:				□Barbiturates (sleeping pills) □Penicillin □Codeine □Sulfa					
				□Iodine □Other					
Cell Phone:				□Latex □ NONE					
Work Phone:									
Health History Physician's Name:		Phone	#:		Last Visit:				
Emergency Contact: Phone #:									
Place a mark on "yes" or	"no" to in	dicate if yo	ou have had a	any of the follow	ving:				
Addiction	□Yes	□No	Diabetes		□Yes		Organ Transplant	□Yes	
AIDS/HIV	□Yes	□No	Epilepsy		□Yes		Other Lung Disease	□Yes	□No
Anemia	□Yes	□No		dizziness			Pacemaker	□Yes	□No
Arthritis	□Yes	□No	Heart Dise		□Yes	□No	PreMed ♥	□Yes	□No
Artificial Valves/Joints	□Yes	□No	Heart Muri		□Yes	□No	Radiation Therapy	□Yes	□No
Asthma	□Yes	□No		e Transplant	□Yes	□No	Respiratory Disease	□Yes	□No
Back Problems	□Yes	□No	Hemophilia		□Yes	□No	Rheumatic Fever	□Yes	□No
Bleeding Abnormally	□Yes	□No	Hepatitis A		□Yes	□No	Scarlet Fever	□Yes	□No
Blood Disease	□Yes	□No	Hepatitis E		□Yes	□No	Sinus Trouble	□Yes	□No
Cancer	□Yes	□No	Hepatitis C		□Yes	□No	Stroke	□Yes	□No
Chemical Dependency	□Yes	□No	Herpes (O		□Yes		Swelling of feet or ankles		□No
Chemotherapy	□Yes	□No	High Blood		□Yes	□No	Thyroid Problems	□Yes	□No
Circulatory Problems	□Yes	□No	Liver Disease		□Yes	□No	Sleep Apnea/ CPAP	□Yes	
Cough, persistent	□Yes	□No	Low Blood Pressure		□Yes	□No	Other		
ADD/ADHD	□Yes	□No	Autism Spectrum		□Yes	□No			
To the best of my knowledge, the above information is correct. I understand that it is my responsibility to inform if I, or my minor child, ever have a									
change in health or insurance.									
V									
X Date Signature of Patient, Parent, Guardian or Legal Representative									
Authorization & Release (relation to patient): □Self □Mother □Father □Guardian									

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