Jeanette Lawson, D.D.S., P.C.
305 Sheridan Rd.
Noblesville, Indiana 46060

PATIENT INFO

First Name ______________________ Middle Initial _______ Last Name ___________________________

Sex: ☐ Male ☐ Female Date of Birth ______________ Age _______ Social Security # _________________

Address ____

City _________________ State ___________ Zip __________ E-Mail ___________________________

Home Phone _______________ Work Phone _______________ext._____ Cell Phone _______________

Employer ____________________________________ Occupation ____________________________

Employer Address ____

Student: ☐ yes ☐ no School Name / Address ____

Married ☐ Single ☐ Widowed ☐ Minor ☐ Other ☐_______________ Spouse's Name _________________

In case of emergency who should be notified?__________________________ Phone _________________

Has anyone else in your family been in our office before? Yes ☐ No ☐ Who?______________________

Who may we thank for referring you to our practice? ____

DENTAL HISTORY

Reason for today's visit _________________________ Date of your last cleaning/exam _________________

Former Dentist _____________________________ Date of last dental x-rays _________________________

Check if you have had problems with any of the following:

☐ Bad Breath
☐ Bleeding Gums
☐ Clicking or Popping of the Jaw
☐ Clinching or Grinding Teeth
☐ Loose Teeth or Broken Fillings
☐ Periodontal Treatment
☐ Sensitivity to Hot / Cold / Sweets
☐ Sores or Growths in Your Mouth
☐ TMJ Disorder

Do you wear dentures or partials? ☐ yes ☐ no If yes, date of placement _____________

How often do you brush? __________ How often do you floss? __________ Are you happy with your smile? ☐ yes ☐ no

Are you having any specific problems with your teeth, gums, or mouth at this time? If yes, please explain ________________
____

Have you had any serious trouble associated with any previous dental treatment? If yes, please explain ________________
____

MEDICAL HISTORY

Physician's Name ____________________________________ Phone ___________________________

Are you currently under the care of a physician? If yes, what is the condition being treated? ___________________
____

Have you had any serious illness, operation, or been hospitalized within the past 5 years? If yes, what was the illness or problem?
____

What medicines or supplements are you currently taking? ______________________________________
____

MEDICAL HISTORY (continued)

Are you allergic to, or have you reacted adversely to any of the following:

- ☐ Local Anesthetic
- ☐ Sedatives/Sleeping Pills
- ☐ Codeine
- ☐ Other ______________________
- ☐ Penicillin
- ☐ Aspirin
- ☐ Iodine
- ☐ Sulfa Drugs
- ☐ Latex
- ☐ Metals

(Women)

Are you pregnant? ☐ yes ☐ no If yes, what is your due date? ______________ Are you currently nursing? ☐ yes ☐ no

Are you on birth control pills / fertility drugs? Please list ______________________________

Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Cancer / Tumor
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting / Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ PRE-MED
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Skin Rashes / Hives
- ☐ Smoker
- ☐ Smokeless Tobacco
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer / Stomach Problems
- ☐ Venereal Disease
- ☐ Other ______________________

INSURANCE COVERAGE

Policy Holder First Name ____________________ Middle Initial ______ Last Name ______________________

Relation to patient ____________________ Date of Birth __________ Social Security # ______________________

Address (if different from patient's) ______________________________ Employer______________________

Insurance Company ______________________________ ID # ______________ Group # ______________

Ins. Co. Address ______________________________________ Ins. Co. Phone ______________

Is patient covered by additional insurance? ☐ yes ☐ no

RESPONSIBLE PARTY (if other than patient)

First Name ______________________ Middle Initial ______ Last Name ______________________

Date of Birth ______________ Age ______ Social Security # ____________ relationship to patient __________

Address ____

Home Phone ______________ Work Phone ______________ext._____ Cell Phone ______________

Employer ______________________________ Occupation ______________________________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medicines change I will inform the office at the next appointment without fail.

Our office policy is that patients with insurance pay their deductible as well as the percentage not paid by their policy at the time services are rendered. This signature on file is my authorization for the release of all information necessary to process my claim. I hereby authorize payment directly to the dentist of the insurance benefits otherwise payable to me for services rendered.

Payment is due in full at the time services are rendered. I understand that I am ultimately financially responsible for all charges incurred including all fees associated with the collection of any delinquent balances on my account.

______________________________ ____________ ____________ ____________ ____________

Signature of patient (or parent/guardian if patient is under 18) | date | initials/ date reviewed | initials/ date reviewed | initials/ date reviewed