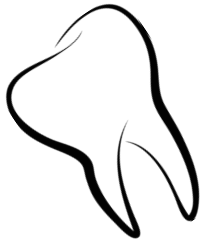
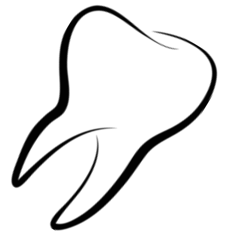


WELCOME



We are pleased to welcome you to be a part of the Dorothy Lane Dental family! Please Take a few minutes to fill out this form as completely as you can. If you have any questions our staff would be more than happy to help you. We look forward to working with you to maintain your dental health!

Patient Information

Name: ____ Soc. Sec. # ________________

Last Name First Name Middle Initial

Address ____

City ___________________ State ________ Zip ___________ Home Phone __________________

Cell Phone __________________________ E-Mail_____________________________________

Sex □M □F Age ________ Birthdate ________________ □ Single □Married □ Separated □Divorced □ Widowed

Responsible Party for Account ____

Last Name First Name Middle Initial

Relationship to patient ___________________ Soc. Sec. # __________________ Birthdate ___________

Address ____

City ___________________ State ________ Zip ___________ Home Phone __________________

Cell Phone __________________________ E-Mail_____________________________________

Whom may we thank for referring you? ____

Notify In case of emergency ______________________________ Home Phone __________________

Cell Phone __________________________ E-Mail_____________________________________

Primary Insurance Information

Policy Holder Name ____

Last Name First Name Middle Initial

Relationship to Patient ___________________ Birthdate _____________ Soc. Sec. # _______________

Address ____

City ___________________ State ________ Zip ___________ Home Phone __________________

Cell Phone __________________________ E-Mail_____________________________________

Insurance Company ____

Insurance Phone _________________________ Group# _______________ ID # _______________

Secondary Insurance Information

Is patient covered by additional insurance? □ Yes □ No

Policy Holder Name ____

Last Name First Name Middle Initial

Relationship to Patient ___________________ Birthdate _____________ Soc. Sec. # _______________

Address ____

City ___________________ State ________ Zip ___________ Home Phone __________________

Cell Phone __________________________ E-Mail_____________________________________

Insurance Company ____

Insurance Phone _________________________ Group# _______________ ID # _______________

Dorothy Lane Dental

Medical History

Are you currently under a physician's care now? □ Yes □ No   If yes why? ______________________________
Have you ever been hospitalized or had a major surgery? □ Yes □ No
If yes why/what for? ______________________________
Have you ever had a serious head or neck injury? □ Yes □ No   If yes what? ______________________________
Taking any medications? □ Yes □ No   If yes what?
____
____
____
Are you on a special diet? □ Yes □No   Do you use tobacco? □ Yes □ No
Do you use a controlled substance? □ Yes □ No   If yes what? ______________________________
Women Only: Are you…
□ Pregnant/Trying to get pregnant   □ Nursing?   □ Taking oral contraceptives?
Do you have any known allergies? □ Yes □ No   If yes what? ______________________________
____
____

Please check if you have, or have you had, any of the following?

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

Other? ______________________________

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes to my medical history I will inform the dentist.
I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Dorothy Lane Dental

Signature ______________________________ **Date** ______________