LYNSEY LINDSTROM, D.D.S.
JODY SESSOM, D.D.S.

PATIENT INFORMATION

Name_____ Home Phone _____Cell Phone_____

Mailing Address_____ City_____ State_____ Zip_____

Birthdate_____ Check Appropriate Box: □ Minor □Student □ Single □ Married □ Divorced □ Widowed □ Separated

Patient's or Parent's Employer_____ Work Phone_____ Cell Phone_____

Business Address_____ City_____ State_____ Zip_____

Email address_____ Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency Phone_____

RESPONSIBLE PARTY INFORMATION

Name of Person Responsible for this Account_____ Relation to Patient_____

Home Address (If different than pt.) _____ City_____ State_____ Zip_____

Birthdate_____ Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Currently a Patient in our Office? □ Yes □ No Is it ok to contact you at work? □ Yes □ No

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relation to Patient_____

Birthdate_____ Social Security # _____**OR** Insurance ID #_____

Insured Address (if different than patient) _____

Employer Name _____ City_____ State_____ Zip_____

Insurance Company Name_____ Group #_____ Union or Local #_____

Insurance Company Address_____City_____State_____Zip_____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relation to Patient_____

Birthdate_____ Social Security # _____**OR** Insurance ID #_____

Insured Address (if different than patient) _____

Employer Name _____ City_____ State_____ Zip_____

Insurance Company Name_____ Group #_____ Union or Local #_____

Insurance Company Address_____City_____State_____Zip_____

--OVER--

DENTAL HISTORY

Reason for today's visit _____ Former Dentist_____

Address_____Phone _____

Date of last dental visit _____ Date of last dental X-rays_____

Check (√) if you have had any of the following:

□Bad breath
□Bleeding gums
□Clicking or popping jaw
□Food collection between the teeth
□Grinding teeth
□Loose teeth or broken fillings
□Periodontal treatment
□Sensitivity to cold
□Sensitivity to heat
□Sensitivity to sweets
□Sensitivity when biting
□Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name_____ Date of last visit _____

Have you had any serious illnesses or operations? □Yes □No If yes, describe_____

Have you ever had a blood transfusion? □Yes □No If yes, give approximate dates_____

(Women) Are you pregnant? □Yes □No Nursing? □Yes □No Taking birth control pills? □Yes □No

Check (√) if you have had any of the following:

□AIDS
□Anemia
□Arthritis, Rheumatism
□Artificial Heart Valves
□Artificial Joints
□Asthma
□Back Problems
□Blood Disease
□Cancer
□Chemical Dependency
□Chemotherapy
□Circulatory Problems
□Cortisone Treatments
□Cough, Persistent
□Cough up Blood
□Diabetes
□Epilepsy
□Fainting
□Glaucoma
□Headaches
□Heart Murmur
□Heart Problems
Describe_____
□Hemophilia
□Hepatitis
□High Blood Pressure
□HIV Positive
□Jaw Pain
□Kidney Disease
□Liver Disease
□Mitral Valve Prolapse
□Nervous Problems
□Pacemaker
□Psychiatric Care
□Radiation Treatment
□Respiratory Disease
□Rheumatic Fever
□Scarlet Fever
□Shortness of Breath
□Skin Rash
□Stroke
□Swelling of Feet or Ankles
□Thyroid Problems
□Tobacco Habit
□Tonsillitis
□Tuberculosis
□Ulcer
□Venereal Disease

MEDICATIONS | ALLERGIES

List medications you are currently taking:

_____

_____

List of Drug Allergies:

_____

_____

AUTHORIZATION AND RELEASE

I am of legal age (18 or older); I authorize the dental staff to discuss my dental treatment with my parents, guardians or spouse until which time I withdraw this authorization. Date & Initial _____.
I authorize the dental staff to call my home and leave a message regarding any per-medication information for my dental treatment if I cannot be reached, until which time I withdraw this authorization. Date & Initial _____
I authorize the dental staff to place my child's picture on the No Cavity Club Board until he or she reaches the age of 13. Date & Initial _____

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.
Signature of Patient or Parent if Minor_____Date_____