



LYNSEY LINDSTROM, 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 _____ Relation _____
Responsible for this Account _____ 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> 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:

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