William L. Lewis D.D.S., P.A. *Welcome to our office*

PATIENT INFORMATION

Patient's Name _____ Birth Date _____ SS# _____

Address _____ City _____ State _____ Zip _____

☐Male ☐Female ☐Married ☐ Single Home Phone_____ Cell Phone _____ Work Phone _____

Employer Name _____ In case of emergency notify _____ Phone _____

Do you have Dental Insurance? _____ Name of Insurance Co._____

Physician's Name _____ Physician's Phone _____

Is this your first visit to this office YES NO If YES who recommended us to you? _____

PLEASE CIRCLE THE APPROPRIATE ANSWER

1. Date of last physical exam_____
2. Has there been a change in your health in the past year? . . . . . YES NO
3. Are you currently under a physician's care? . . . . . YES NO
4. Have you had any surgeries in the past 2 years? . . . . . YES NO

if so, for what?_____

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5. Do you have or have you ever had any of the following:
   - a. Rheumatic fever or Rheumatic heart disease . . . . . YES NO
   - b. Congenital heart disease . . . . . YES NO
   - c. Heart Murmur . . . . . YES NO
   - d. Stroke . . . . . YES NO
   - e. High blood pressure . . . . . YES NO
   - f. Diabetes . . . . . YES NO
   - g. Heart Attack . . . . . YES NO
   - h. Arteriosclerosis . . . . . YES NO
   - i. Heart trouble . . . . . YES NO
   - j. Allergy or hay fever . . . . . YES NO
   - k. Asthma . . . . . YES NO
   - l. Hives or skin rash . . . . . YES NO
   - m. Hepatitis . . . . . YES NO
   - n. Jaundice . . . . . YES NO
   - o. Liver Disease . . . . . YES NO
   - p. Arthritis or Inflammatory Rheumatism (painful swollen joints) . . YES NO
   - q. Stomach ulcers . . . . . YES NO
   - r. Kidney trouble . . . . . YES NO
   - s. Tuberculosis . . . . . YES NO
   - t. Substance abuse (alcoholism, drug addiction) . . . . . YES NO
   - u. Persistent cough or cough up blood . . . . . YES NO
   - v. Epilepsy or seizure disorder . . . . . YES NO
   - w. Venereal disease (syphilis, gonorrhea, other) . . . . . YES NO
6. Have you had any placement of artificial joints, (such as knee, hip, and shoulder) or a heart valve replacement? . . . . . YES NO
7. Have you ever tested positive for HIV or AIDS? . . . . . YES NO
8. Do you have pain in your chest upon exertion? . . . . . YES NO
9. Do your ankles swell? . . . . . YES NO
10. Have you had abnormal bleeding associated with previous surgery, extractions, or accidents? . . . . . YES NO
11. Do you have any blood disorders such as anemia, etc.? . . . . . YES NO
12. Have you ever been treated for a tumor, growth or other condition with surgery or x-ray treatment? . . . . . YES NO
13. Are you taking any medication? . . . . . YES NO
    If so, please list the names of the drugs on Page 2.
14. Are you taking any of the following drugs?
    - a. Antibiotics or sulfa drugs . . . . . YES NO
    - b. Anticoagulants (blood thinners) . . . . . YES NO
    - c. Medicine for high blood pressure . . . . . YES NO
    - d. Cortisone or steroids . . . . . YES NO
    - e. Tranquilizers . . . . . YES NO
    - f. Aspirin (more than 2 per day) . . . . . YES NO
    - g. Dilantin, or any other anti-convulsant . . . . . YES NO
    - h. Insulin, Tolbutamide, Orinase or any other diabetic drug . . . . . YES NO
    - i. Digitalis or any other for heart trouble . . . . . YES NO
    - j. Nitroglycerin . . . . . YES NO
    - k. Narcotic analgesic (or any other strong pain medicine) . . . . . YES NO
    - l. Birth Control "Pill" . . . . . YES NO
    - m. Alcohol, antabuse . . . . . YES NO
    - n. Recreational drugs . . . . . YES NO
15. Are you allergic to or have you ever reacted adversely to any of the following?
    - a. Local anesthetics (Novacaine, Lidocaine, etc.) . . . . . YES NO
    - b. Penicillin (or other antibiotic-please list) . . . . . YES NO

    _____

    Any other not mentioned_____

    _____

    _____
16. Have you had any serious trouble associated with any previous dental treatment? . . . . . YES NO
    If so, please explain_____

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(Page 1- continued on other side)

17. Date of last dental exam_____

18. Have you ever been treated for any gum diseases, (gingivitis, periodontitis, trench mouth, or pyorrhea)? . . . . . YES NO

19. Do your gums bleed when you brush or floss? . . . . . YES NO

20. Do you grind or clench your teeth? . . . . . YES NO

21. Have you had frequent sores in your mouth? . . . . . YES NO

22. Have you had any injuries to your mouth or jaw? . . . . . YES NO

If so, please explain_____

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_____

23. Do you have any sores or swellings of your mouth or jaw? . . . . . YES NO

24. Are you interested in keeping your teeth? . . . . . YES NO

25. Have you been satisfied with your previous dental care? . . . . . YES NO

If not, please explain_____

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26. Women
Are you pregnant? . . . . . YES NO

Current Medications

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Medical Update (for office use only)

Date _____ Date _____

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NOTICE OF PRIVACY PRACTICES: You have the right to read our Privacy Practices before you decide whether to sign this consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took prior to receiving your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature: _____ Date: _____

If this consent is signed by a parent/personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____