Dr. Lanette M. Disera D.D.S.

GENERAL DENISTRY

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About You

Todays date: _____ SS #: _____

Patient name Last: _____ First: _____ MI: ____

What you prefer to be called: _____ ☐ Male ☐ Female Birth date: _____ Age: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Home phone #: _____ Work phone #: _____

Cell phone #: _____ Email: _____

Referred by: _____ Occupation: _____

Employer:_____ How long:_____

Employers address: _____ City: _____ State: _____ Zip: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's name: _____ Do you have children: ☐ Yes ☐ No How many: ____

Account Information Person ultimately responsible for account.

Name: _____ Relation: _____

Billing address: _____ City: _____ State: _____ Zip: _____

Drivers license #: _____ Work phone #: _____

Payment method: ☐ Cash ☐ Check ☐ Credit card _____ ___/___

☐ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Insurance Information

Primary dental insurance Company name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Insured's ID #: _____

Group # (Plan, Local, or Policy #): _____

Insured's name: _____ Relation: _____ Birth date: _____

Insured's employer: _____

Secondary dental insurance Company name: _____

Insured's ID #: _____ Group # (Plan, Local, or Policy #): _____

Insured's name: _____ Relation: _____ Birth date: _____

Insured's employer: _____

In Event of Emergency

Whom should we contact: _____ Relation: _____

Home phone #: _____ Work phone #: _____

Cell phone #: _____

Who is your medical doctor: _____ Phone #: _____

Health Information

☐ HIV/Aids	☐ Diabetes	☐ Heart Murmur	☐ Radiation or Chemo
☐ Allergies	☐ Dizziness	☐ Hepatitis	☐ Respiratory Problem
☐ Anemia	☐ Epilepsy	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Arthritis	☐ Excessive Bleeding	☐ Kidney Disease	☐ Sinus Problems
☐ Artificial Joints	☐ Fainting	☐ Liver Disease	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Mental Disorders	☐ Tuberculosis
☐ Blood Disease	☐ Head Injuries	☐ Pacemaker	☐ Tumors
☐ Cancer	☐ Heart Disease	☐ Pregnancy _____	☐ Ulcers

☐ Medication Allergies: Please list.

_____

Have you ever had any complications following dental treatment: ☐ Yes ☐ No

If yes please explain: _____

Have you been admitted to a hospital or needed emergency treatment during the past two years:

☐ Yes ☐ No

If yes please explain: _____

Are you under the care of physician: ☐ Yes ☐ No

Name of physician: _____

Are you taking osteoporosis meds at this time: ☐ Yes ☐ No

Do you have any health problems not listed above: _____

Please list any medications or herbal supplements you are taking at this time:

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change to my health, I will inform the doctors at the next appointment without fail.

Signature of patient: _____ Date: _____

How did you hear about our office? _____

A $75 fee will be enforced for all missed appointments without a 24 hour notice.
Appointments over 1 hour in length may be assessed an additional $75. Please initial _____