WELCOME TO LAFAYETTE FAMILY DENTISTRY

ABOUT YOU

Today's date:_____ ○ Male ○ Female
Name:_____
last first middle
Preferred name:_____
Birthday:__/__/__ Age:___ SS#_____
Home Address:_____
apt#
_____
city state zip
○ Single ○ Married ○ Divorced ○ Widowed ○ Separated
Home:(____)_____ Mobile:(___)_____
Text: YES NO
Work:(____)_____ Ext:___
Email Address:_____
Employer:_____
Employer's Address:_____
How long there?_____ Occupation:_____
Where & when are best time to reach you?_____
Whom may we thank for referring you?_____
Other family members seen by us:_____
Previous/Present Dentist:_____
Last Dental Visit Date:_____

INSURANCE

Primary Ins.
Dental Coverage? ○ Yes ○ No
Ins. Co Name:_____
Ins. Co Address:_____
Ins. Co Phone#:(___)_____
Group#:_____
Insured's Name:_____ Relation:_____
Insured's Birthday:__/__/__ Insured's ID#:_____
Insured's Employer:_____
Employer's Address:_____

Secondary Ins.
Dental Coverage? ○ Yes ○ No
Ins. Co Name:_____
Ins. Co Address:_____
Ins. Co Phone#:(___)_____
Group#:_____
Insured's Name:_____ Relation:_____
Insured's Birthday:__/__/__ Insured's ID#:_____
Insured's Employer:_____
Employer's Address:_____

SPOUSE INFORMATION

Name:_____Birthday:__/__/__SS#:_____
Employer:_____Work(___)_____Ext:____

Person Responsible for Account:_____
Work:(___)_____ Ext:____ Home:(___)_____
Billing Address:_____ Relationship:_____
SS#:_____ Employer:_____

Emergency Contact
Name:_____ Relation:_____
Work:(___)_____ Home:(___)_____
Address:_____
_____
city state zip

Payment is due in full at time of treatment
(unless prior arrangements have been approved)
If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Dr. Sue VanBlaricum of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
signature date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

412 College St. Lafayette, TN 37083 Phone: 615-666-6155 www.lafayettefamilydentistry.com

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MEDICAL HISTORY

Do you have a personal physician? YES NO
Physician's Name:_____
Phone: ( )_____ Date of last visit:_____
Are you currently under the care of a physician? YES NO
If yes please explain:_____
Your current physical health is GOOD FAIR POOR
Do you smoke or use tobacco in any other form? YES NO
Have you had any metal rods, pins, or implants? YES NO
Have you ever taken Phen Fen? (Known as Redux or Pandimin) YES NO
FOR WOMEN: Are you using a prescribed method of birth control? YES NO
Are you pregnant? YES NO Week #_____
Are you nursing? YES NO

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Anemia
Y N Arthritis
Y N Alcohol / Drug Abuse
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherpy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV / AIDS
Y N Hospitalized for any reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatments
Y N Rheumatic / Scarlet Fever
Y N Seizers
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis
Y N Ulcers
Y N Venereal Disease

Please list any serious medical conditions that you have ever had:_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs / materials that you are allergic to:_____

Are you taking any prescription / over the counter / herbal supplement drugs? Please list each one:_____