Mountain View Dentistry

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Patient Information and Medical History

Name ______________________ **Home Phone** ____________

Address ______________________ **Cell Phone** ____________

City/State/Zip ______________________ **Work Phone** ____________

E-mail Address ____________ **Sex** ______ Are You in Good Health? Yes ◯ No ◯

Birthdate ____________ **Marital Status** ____________ Are you under the care of a Physician? Yes ◯ No ◯

List ALL Medications you are currently taking
(Including non-prescription and Herbal)

1 ______________________
2 ______________________
3 ______________________
4 ______________________
5 ______________________

Physician Name [ ]
Address [ ]
Phone # [ ]

Date of Last Cleaning ______________________

Reason for Today's Visit ______________________

Please Check any Current or Past Medical Conditions

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bisphosphonate Therapy
- ☐ Bleeding Gums
- ☐ Bruise or Bleed Easily
- ☐ Cancer
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Breathing Difficulty
- ☐ Do You Snore
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ HIV+ or AIDS
- ☐ Heart Attack
- ☐ Hepatitis A, B C Other
- ☐ Hemophelia
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Pain in Jaw Joint
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Reaction to Anesthetic
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Tooth Pain
- ☐ Loose Teeth
- ☐ Broken Teeth
- ☐ Gum Disease
- ☐ Bad Breath
- ☐ Smoke
- ☐ Hot/Cold Sensitivity
- ☐ Chewing Sensitivity

For Women Only

- ☐ Are You Nursing?
- ☐ Are You Pregnant?

Due Date ____________

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other

Patient Information and Insurance Data

Patient Information

Place of Employment ______________________ **Occupation** ______________________

Employment Address ______________________

City/State/Zip ______________________ **Phone** ______________________

Emergency Contact ______________________ **Phone** ______________________

Responsible Party

Name ______________________

Address ______________________

Employer ______________________

Relationship ______________________

Home Phone ______________________

Work Phone ______________________

Dental Insurance Information

Name of Insured ______________________

Relationship __________ **Birthdate** __________

Insurance Company ______________________

SS Number ______________________

Group Number __________ **Policy Number** __________

Ins. Co. Address ______________________

City/State/Zip ______________________

Ins. Co. Phone __________ **Member ID #** __________

Do You have Dental Insurance? ◯ Yes ◯ No — If Yes, Complete the information above in Dental Insurance Information

Do You have Medical Insurance? ◯ Yes ◯ No — If Yes, Complete the information below in Medical Insurance Information

Are You a Disabled Veteran? ◯ Yes ◯ No — If yes, Indicate the percentage of disability ______ %

Medical Insurance Information

Name of Insured ______________________

Relationship __________ **Birthdate** __________

Insurance Company ______________________

SS Number ______________________

Group Number __________ **Policy Number** __________

Ins. Co. Address ______________________

City/State/Zip ______________________

Ins. Co. Phone ______________________

Member ID # ______________________

Payment is due when services are rendered. I understand that I am responsible for professional fees incurred on my behalf regardless of my insurance status.
I understand that I am responsible for all costs incurred by Lanier Dental Group, Inc. DBA Mountain View Dentistry. in the event my account is turned over to an outside agency for collections. Accounts over 30 days past due will be charged interest at the rate of 1.5% monthly on your account balance. I authorize Lanier Dental Group DBA Mounatin View Dentistry to E-mail appointment reminders, post operative instructions and treatment plan presentations to the address given above.
I certify that I have read and understand both sides of this form and that my responses are true and correct.

Patient Signature ______________________ Date __________

Parent or Guardian if Patient is a Minor