John F Lann D.D.S.

Patient Information

Patient Name: ______________________________ Date: __________
Last, First MI (Preferred Name)

Drivers License # __________________ Social Security #: ________ Birth Date: ______________

Phone (Home): ____________ (Work): ____________ Ext: ________ Cell: ______________

Address: ____

E-Mail: ______________________________ Would you like to receive email reminders: ________

Referral Information

Whom may we thank for referring you to our practice?

Health Information

Date of Last Dental Visit: ______________ Reason for this visit: ______________________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies
  (**Please circle**)
  - *Codeine
  - *Penicillin
  - *Seasonal
  - *Other____________
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Other: ______________

- *Have you been admitted to a hospital or needed emergency care during the past two years?* ☐ Yes ☐ No
  If yes, please explain: ______________________________
- *Are you now under the care of a physician?* ☐ **Yes** ☐ **No** *Name of Physician/Phone #:* ______________
  If yes, please explain: ______________________________
- *Are you taking any medications?* ☐**Yes** ☐**No** *Please list:* ______________________

Dental History

1) *Do your gums bleed while brushing or flossing?* ☐ **yes** ☐ **no**
2) *Are your teeth sensitive to hot or cold liquids/foods?* ☐ **yes** ☐ **no**
3) *Do you feel pain to any of your teeth?* ☐ **yes** ☐ **no**
4) *Have you had any head, neck or jaw injuries?* ☐ **yes** ☐ **no**
5) *Have you ever experienced any of the following problems in your jaw?*
   - *A) Clicking?* ☐ **yes** ☐ **no**
   - *B) Pain (Joint, Ear, Side of Face)?* ☐ **yes** ☐ **no**
   - *C) Difficulty in Opening or Closing?* ☐ **yes** ☐ **no**
   - *D) Difficulty in Chewing?* ☐ **yes** ☐ **no**

Comments: ______________________

- *Have you ever had any complications following dental treatment?* ☐ **Yes** ☐ **No**
  If yes, please explain: ______________________________

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

______________________________ *Date:* ______________
Signature of patient, parent or guardian

Dental Insurance Information

Primary

Name of Insured: ______________________________ (Last / First / MI) Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________ (Street / City / State / Zip Code)

Insured's Employer Name: ______________________________

Address: ______________________________ (Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ______________________________

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Secondary

Name of Insured: ______________________________ (Last / First / MI) Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________ (Street / City / State / Zip Code)

Insured's Employer Name: ______________________________

Address: ______________________________ (Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ______________________________

____

Emergency Contact

Person to contact in case of an emergency: ______________________________ (Relationship)

____

Phone / Cell / Work

Consent for Services

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr Lann and staff if I, or my minor child, ever have a change in health.

*I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to **Dr Lann** all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.*

The above-names dentist may use my health care information and may disclose such information to the above-names Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is complete or one year from the date signed below.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: ____________ Relationship to Patient: ____________

Signature of patient, parent or guardian

______________________________ Date: ____________ Relationship to Patient: ____________

Signature of guarantor of payment/responsible party