Legacy Dental

Thank You for Selecting Our Dental Team

To help us meet all of your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name ____________________ Date ____________________

Soc. Sec. # ____________________ Birthdate ____________________

Home Telephone ____________________ Cell Phone ____________________

Address ____________________ City ____________________ State ______ Zip ____________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School / College ____________________ City ____________________ State ______

Patient's or Parent's Employer ____________________ Work Phone ____________________

Business Address ____________________ City ____________________ State ______ Zip ____________

Spouse or Parent's Name ____________________ Employer ____________________ Work Phone ____________________

Whom May We Thank for Referring You? ____________________

Emergency Contact: Name ____________________ Telephone ____________________

Responsible Party

Name of Person Responsible for this Account ____________________ Relationship to Patient ____________________

Address ____________________ Home Phone ____________________

Employer ____________________ Work Phone ____________________ S. S. # ____________________

Is This Person Currently a Patient in Our Office? ___ Yes ___ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each visit.

___Cash ___Personal Check Credit Card: ___VISA ___MasterCard ___I wish to discuss the office's payment policy.

Dental Insurance Information

Name of Insured ____________________ Relationship to Patient ____________________

Birthdate ____________ Soc. Sec. # ____________________ Date Employed ____________________

Name of Employer ____________________ Union or Local # ____________ Work Phone ____________________

Employer Address ____________________ City ____________________ State ____________ Zip ____________

Insurance Company ____________________ Group # ____________________ Policy/ID # ____________________

Ins. Co. Address ____________________ City ____________________ State ____________ Zip ____________

How Much is Your Deductible? ____________ How Much Have You Used? ________ Max. Annual Benefit? ____________

Do you have any additional dental insurance? ___ Yes ___ No If yes, please complete the following.

Name of insured ____________________ Relationship to Patient ____________________

Birthdate ____________ Soc. Sec. # ____________________ Date Employed ____________________

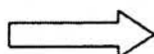
Name of Employer ____________________ Union or Local # ____________ Work Phone ____________________

Employer Address ____________________ City ____________________ State ____________ Zip ____________

Insurance Company ____________________ Group # ____________________ Policy/ ID # ____________________

Ins. Co. Address ____________________ City ____________________ State ____________ Zip ____________

How Much is Your Deductible? ____________ How Much have You Used? ________ Max. Annual Benefit? ____________



Over, Please

Patient Medical History

Legacy Dental

Medical Doctor______________________ Office Phone ______________ Date of Last Exam __________

	Question	Yes	No
1.	Are you under medical treatment now?	____	____
2.	Have you ever been hospitalized for any surgical operation in the past five years? If yes, please explain:__________________	____	____
3.	Are you taking any medications, including non-prescription medicine? If yes, what medication(s)?______________	____	____
4.	Have you ever taken Fosamax?	____	____
5.	Do you use tobacco?	____	____
6.	Do you use controlled Substances?	____	____
7.	Are you wearing contact lenses?	____	____

8. Are you allergic to or have you had any reactions to any of the following:

	Yes	No
Any metals (eg. nickle, mercury, etc.)?	____	____
Seasonal Allergies?	____	____
Amoxicillin?	____	____
Aspirin?	____	____
Pain Meds? What?	____	____
Erythromycin?	____	____
Iodine?	____	____
Latex rubber?	____	____
Local Anesthetics? What?	____	____
Penicillin?	____	____
Sulfa Drugs?	____	____
Xylocaine?	____	____
Other		

9. Women Only: Are you pregnant or think that you may be pregnant? ____ Yes ____ No
Are you nursing? ____ Yes ____ No
Are you taking oral contraceptives? ____ Yes ____ No

PLEASE NOTE: The effectiveness of oral contraceptives may be reduced when taking some antibiotics, including amoxicillin.

10. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Angina	____	____	Heart Murmur	____	____	Reaction to Epinephrine	____	____
Arthritis	____	____	Heart Pacemaker	____	____	Osteoporosis	____	____
Artificial Joints (hip/knee)	____	____	Heart Problems/Attack	____	____	Radiation Treatment	____	____
Asthma	____	____	Heart Surgery	____	____	Recent Weight Loss	____	____
Bleeding Disorder	____	____	Hepatitis	____	____	Respiratory Problems	____	____
Blood Disorder	____	____	High Blood Pressure	____	____	Rheumatic Fever	____	____
Blood Transfusion	____	____	High Cholesterol	____	____	Sinus Trouble	____	____
Cancer/Chemo	____	____	HIV Positive/AIDS	____	____	Splenectomy	____	____
Coumadin/Blood Thinner	____	____	Irregular Heart Beat	____	____	Stroke	____	____
Diabetes	____	____	Liver Disease	____	____	Strong Gag Reflex	____	____
Drug Addiction	____	____	Low Blood Pressure	____	____	Thyroid Condition	____	____
Emphysema/COPD	____	____	Mitral Valve Prolapse	____	____	Tuberculosis	____	____
Epilepsy/Seizures	____	____	Multiple Sclerosis	____	____	Vertigo	____	____
Glaucoma	____	____	Other ______________			Vision Impaired	____	____
Hearing Impaired	____	____						

Patient Dental History

Name of Previous Dentist (only for new patients)______________________ Date of Last Exam __________

	Question	Yes	No
1.	Do your gums bleed when brushing or flossing?	____	____
2.	Are your teeth sensitive to hot or cold?	____	____
3.	Are your teeth sensitive to sweet/sour?	____	____
4.	Do you feel pain in any of your teeth?	____	____
5.	Do you have any sores or lumps in or near your mouth?	____	____
6.	Have you had any head, neck, or jaw injuries?	____	____
7.	Have you ever experienced any of the following problems in your jaw?		
	Clicking?	____	____
	Pain (joint, ear, side of face)?	____	____
	Difficulty in opening or closing your mouth?	____	____
8.	Do you have frequent headaches?	____	____
9.	Do you clench or grind your teeth?	____	____
10.	Do you bite your lips/cheeks frequently?	____	____
11.	Have you had difficult extractions in the past?	____	____
12.	Have you ever had prolonged bleeding after extractions?	____	____
13.	Have you had any orthodontic treatment?	____	____
14.	Do you wear dentures or partials?	____	____
15.	Have you ever received oral hygiene instructions?	____	____
16.	Do you like your smile?	____	____
17.	Do you participate in contact sports?	____	____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X______________________________ **DATE**__________
Signature of patient (or parent or guardian, if minor)

X______________________________ **DATE**__________
Signature of patient (or parent or guardian, if minor)

X______________________________ **DATE**__________
Signature of patient (or parent or guardian, if minor)

For OFFICE USE: Reviewed by Dr. ______________________ Date__________ Date__________ Date__________