Welcome to Lincoln Dental

Patient Information **Date:**_____

Name: _____ Person Responsible for Account: __ Self __ Other_____
Last First MI

Address: _____
Street Apt# City State Zip code

Home Phone: _____ Cell Phone: _____ D.O.B. _____

Email: _____ Social Security # _____

Primary Dental Insurance: _____ ID # _____

D.O.B. of Primary Member _____ Employer of Primary Member_____

Secondary Insurance: _____ ID# _____

D.O.B. Of Primary Member _____ Employer of Primary Insurance _____

Emergency Contact: Name: _____ Phone: _____

Medical History

Are you under a physicians care now? Why? _____ Who? _____ Phone? _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Allergies-please list any allergies that you have _____ Yes No
List any medications you take, including over the counter _____
_____ Yes No
Women: __ Pregnant/trying to get pregnant __ Nursing __ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Please circle Yes or No for every question.
*If yes to any starred conditions, please call prior to your appointment...pre-medication may be required.

Heart Trouble/Surgery	Yes No	Bruise Easily	Yes No	Emphysema	Yes No	Yellow Jaundice	Yes No
Heart Murmur*	Yes No	Anemia	Yes No	Tuberculosis	Yes No	Kidney Problems	Yes No
Mitral Valve Prolapse	Yes No	Excessive Bleeding	Yes No	Cancer	Yes No	Renal Dialysis	Yes No
Angina/Chest Pain	Yes No	Sickle Cell Disease	Yes No	Radiation	Yes No	Thyroid Disease	Yes No
Congenital Heart Disorder	Yes No	Hemophilia	Yes No	Chemotherapy	Yes No	Parathyroid Disease	Yes No
Heart Attack/Failure	Yes No	Leukemia	Yes No	Stomach Diseas e	Yes No	Arthritis/Gout	Yes No
Scarlet Fever	Yes No	Recent Blood Trans.	Yes No	Ulcers	Yes No	Rheumatism	Yes No
Rheumatic Fever*	Yes No	Swelling of Limbs	Yes No	Recent Weight Loss	Yes No	Pain In Jaw Joints	Yes No
Artificial Heart Valve*	Yes No	Lung Disease	Yes No	Frequent Diarrhea	Yes No	Cortisone Medications	Yes No
Pace Maker*	Yes No	Breathing Problems	Yes No	Diabetes	Yes No	Artificial Joint*	Yes No
High/Low Blood Pressure	Yes No	Frequent Cough	Yes No	Excessive Thirst	Yes No	Venereal Disease	Yes No
Unexplained Fever	Yes No	Hay Fever	Yes No	Hypoglycemia	Yes No	Aids/HIV	Yes No
Cold Sores	Yes No	Sinus Trouble	Yes No	Liver Disease	Yes No	Herpes/Genital Herpes	Yes No
Convulsions	Yes No	Asthma	Yes No	Hepatitis A/B/C	Yes No	Drug Addiction	Yes No
Tumors or growths	Yes No	Blood Sputum	Yes No	Night Sweats	Yes No	Tattoos	Yes No
Epilepsy or Seizures	Yes No	Nervousness	Yes No	Fainting or Dizziness	Yes No	Stroke	Yes No
Psychiatric Care	Yes No	Hives or Rash	Yes No	Glaucoma	Yes No	Alzheimer's Disease	Yes No
Allergies(Medication)	Yes No	Allergies(Pollen/Dust)	Yes No	Need Pre-Medication	Yes No		

Have you ever had any serious illness not mentioned above? Discuss_____ Yes No
Do you wish to talk to the dentist privately about any problems?_____ Yes No
X_____ Date:_____
PATIENT SIGNATURE (PARENT or GUARDIAN)
_____Doctor Signature Date _____-

Authorization: I hereby authorize payment directly to Lincoln Dental insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Lincoln Dental to administer such medications and perform such diagnostic, radiographs, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge. I grant the right to the dentist to release this information to the third party payers and/or other health professional.

Billing: In order to keep fees down, payment is due at time of service. If we do not receive payment from your Insurance Company, or payment is forwarded directly to you, you are financially responsible. (See* disclosure below)

X _____ Date _____

***Disclosure:** By signing above I hereby agree, to accept full responsibilities for all charges rendered to this account. Lincoln Dental will make every attempt to collect insurance payments on your behalf, but cannot be held responsible if your insurance does not forward payment and/or settles for less than the estimated payment most insurance companies pay. All estimates given are estimates only, and are not a guarantee of payment. Due to the various insurances available today, the responsible party assumes full-responsibility for understanding their insurance details and benefits since the contract is between the responsible party and the insurance company.