

PATIENT REGISTRATION

First Name: _____ MI _____ Last Name: _____

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Preferred Doctor: Kurt Loveless, D.D.S. Jimmy Lovering, D.D.S. James Lemon, D.D.S.

Patient Information

Address: _____ Address 2: _____
City: _____ State / Zip _____ Fax # _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: _____ Age: _____ Soc. Sec: _____
E-mail: _____ Preferred Correspondence: E-mail Text Both Phone Only

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____
Address: _____ Address 2: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____
Birth Date: _____ Soc. Sec: _____
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Employment Status: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Retired <input type="radio"/> Not Applicable	Referred by: _____
Student Status: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Not Applicable	Relationship: _____
Employer/School: _____ Employer Phone: _____	Emergency Contact: _____
Pref. Pharmacy: _____ Pharmacy Phone: _____	Phone: _____
	Address: _____
	City State Zip

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Employer: _____ Employer Address: _____
Employer City, State, Zip: _____ Employer Address 2: _____
Ins. Company: _____ Ins. Co. Address: _____
Ins. Co. City State, Zip: _____ Ins. Co. Phone: _____
Member ID: _____ Birth Date: _____ Group #: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Employer: _____ Employer Address: _____
Employer City, State, Zip: _____ Employer Address 2: _____
Ins. Company: _____ Ins. Co. Address: _____
Ins. Co. City State, Zip: _____ Ins. Co. Phone: _____
Member ID: _____ Birth Date: _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor and designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

MEDICAL HISTORY

PATIENT NAME _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please list current physicians _____

Have you ever been hospitalized or had a major operation? Yes No If Yes: _____

Have you ever had a serious head or neck injury? Yes No If Yes: _____

Please list any medications, pills, or drugs _____

Do you take or have you taken, medications for Yes No If Yes: _____
osteoporosis or bone health?

Are you on a special diet? Yes No If Yes: _____

Do you use tobacco? Yes No If Yes: _____

Do you use controlled substances? Yes No If Yes: _____

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you ALLERGIC to any of the following? _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Do you have or have you had, any of the following?

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If Yes: _____

Have you ever had: Osteoporosis Yes No ; Osteopenia Yes No ; Endocarditis Yes No

Comments: _____

*Condition may require medication

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

DATE

Patient Name _____
 Patient Account No. _____

DENTAL HISTORY

Medical Alert _____

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or Cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

Dr. Kurt Loveless, Dr. Jimmy Lovering, Dr. James Lemon
2420 Quaker Ave., Suite 104
Lubbock, TX 79410

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment.

I have received a copy of this office's Notice of Privacy Practices.

Print Name

Signature

For Our Office's Use Only

Our office attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

____ Patient refused to sign

____ Communication barriers prohibited obtaining acknowledgment

____ An emergency situation prevented obtaining acknowledgment

____ Other (describe below)

