LAKE COUNTRY DENTAL
RAY D. SNIDER, D.D.S., and ASSOCIATES
Cosmetic, Family and Implant Dentistry

WELCOME TO OUR PRACTICE

Patient Information

Name: ______________________________ Date: __________

Address: ______________________________ City/State/Zip: __________________

Phone: HM (_____)____________ WK (______) ________________ CELL (______) ______________

Birthdate: ____________________ Social Security #: __________________ Age: ______________

Driver License #: ___________ State: ______ Please circle: Male / Female Married / Single / Divorced / Widowed

Responsible Party Information

Name: ______________________________ Social Security #: ______________________

Address: ______________________________ City/State/Zip: __________________

Phone: HM (_____) ______________ Relationship to Patient: ______________________

Birthdate: ____________________ Social Security #: __________________ Age: ______________

Employer: ____________________________ Occupation: ______________________________

Business Address: ______________________________ Business Phone: ______________

How would you like to pay for today's visit? Credit Card / Check / Cash / Monthly Payments with approved credit

Insurance Information

Primary Insurance Co.: ______________________________ Phone: (_____)____________

Employer: ______________ Group #: __________________ Employee Name: ______________

Birthdate: ____________ S.S.#: __________________ Employee #: ______________________

Secondary Insurance Co.: ______________________________ Phone: (_____)____________

Employer: ______________ Group #: __________________ Employee Name: ______________

Birthdate: ____________ S.S.#: __________________ Employee #: ______________________

Getting To Know You

Are other members of your family patients at our office? YES / NO

Name(s): ______________________________________ Relationship: ______________

Name(s): ______________________________________ Relationship: ______________

How did your hear about our office? ______________________________________

Person to contact for emergency: __________________________ Phone: (_____) ______________

Address: ____

Dental Health History (Confidential)

Reason for today's visit?: ____

Why did you leave your former dentist? ______________________ Date of last x-rays: __________

Do you have problems with any of the following:

____ Mouth Odor	____ Grinding Teeth	____ Heat Sensitivity
____ Bleeding Gums	____ Loose Teeth or Broken Fillings	____ Sweet Sensitivity
____ Clicking or Popping Jaw	____ Peridontal Disease/Treatment	____ Sensitivity to Biting Pressure
____ Food Collection Between Teeth	____ Cold Sensitivity	____ Sores or Growths in Mouth

How often do you floss? ____________________ How often do you brush? ________________

Medical History (Confidential)

Physician's Name: ______________________________ Date of Last Visit: ______________

Have you had any serious illnesses or operations? YES/NO If yes describe: __________________

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Have you ever had a blood transfusion? YES/NO If yes give approximate date(s): ______________

(Women) Are you pregnant? YES/NO Nursing? YES/NO Taking Birth Control Pills? YES/NO

Check if you have or have had any of the following:

____ AIDS	____ Cortisone Treatments	____ Hepatitis Type ______	____ Rheumatic Fever
____ Anemia	____ Cough, Persistent	____ High Blood Pressure	____ Scarlet Fever
____ Arthritis, Rheumatism	____ Cough up Blood	____ HIV Positive	____ Shortness of Breath
____ Artificial Heart Valves	____ Diabetes	____ Jaw Pain	____ Skin Rash
____ Artificial Joints	____ Epilepsy	____ Kidney Disease	____ Stroke
____ Asthma	____ Fainting	____ Liver Disease	____ Swelling of Feet or Ankles
____ Back Problems	____ Glaucoma	____ Mitral Valve Prolapse	____ Thyroid Problems
____ Blood Disease	____ Headaches	____ Nervous Problems	____ Tobacco Habit
____ Cancer	____ Heart Murmur	____ Pacemaker	____ Tonsillitis
____ Chemical Dependency	____ Heart Problems __________	____ Psychiatric Care	____ Tuberculosis
____ Chemotherapy	____________________	____ Radiation Treatment	____ Ulcer
____ Circulatory Problems	____ Hemophilia	____ Respiratory Disease	____ Venereal Disease

Do you need Antibiotic Premedication prior to dental treatment? YES / NO

List medications you are currently taking: ______________________________________

Allergies: ____ Aspirin ____ Penicillin ____ Codeine ____ Local Anesthetic Other: ____________________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information cab be dangerous to my health. I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include, but are not limited to bruising, hematoma; cardiac stimulation; temporary or rarely, permanent numbness; or muscle soreness. 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 payers 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. In the event any dispute or claim arising from dental treatment or insurance claims cannot be settled by parties involves, all parties agree to submit said dispute to binding arbitration.

Date: ______________ **Signature**: ______________________________

Dr. Notes: ____

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