

John A. Lindsay

D.D.S., P.A.

Periodontics and Oral Implantology

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Name _____	Birthdate _____	Home Phone _____
Address _____	City _____	State/Prov. _____ Zip/C. _____
Email _____	Cell Phone _____	
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		
If Student, Name of School / College _____		City _____
Patient or Parent/Guardian's Employer _____		Work Phone _____
Business Address _____		City _____
Spouse or Parent/Guardian's Name _____		Employer _____
Whom May We Thank for Referring You? _____		Work Phone _____
Person to Contact in Case of Emergency _____		Phone _____

Responsible Party

Name of Person Responsible for this Account _____	Relationship to Patient _____	
Address _____	Home Phone _____	
Email _____	Cell Phone _____	
Driver's License # _____	Birthdate _____	Financial Institution _____
Employer _____	Work Phone _____	SS#/SIN _____

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 appointment.

Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____	Relationship to Patient _____		
Birthdate _____	SS#/SIN _____	Date Employed _____	
Name of Employer _____	Union or Local # _____	Work Phone _____	
Address of Employer _____	City _____	State/Prov. _____ Zip/C. _____	
Insurance Company _____	Group # _____	Policy/ID # _____	
Ins. Co. Address _____	City _____	State/Prov. _____ Zip/C. _____	
How Much is your Deductible? _____		How Much Have You Used? _____	Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____	Relationship to Patient _____		
Birthdate _____	SS#/SIN _____	Date Employed _____	
Name of Employer _____	Union or Local # _____	Work Phone _____	
Address of Employer _____	City _____	State/Prov. _____ Zip/C. _____	
Insurance Company _____	Group # _____	Policy/ID # _____	
Ins. Co. Address _____	City _____	State/Prov. _____ Zip/C. _____	
How Much is your Deductible? _____		How Much Have You Used? _____	Max. Annual Benefit _____

Patient Medical History

Physician _____	Office Phone _____	Date of Last Exam _____		
1. Are you under medical treatment now? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	9. Are you allergic to or have you had any reactions to the following? _____	
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? _____ If yes, please explain _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Local Anesthetics (e.g. Novocain) _____ Penicillin or any other Antibiotics _____ Sulfa Drugs _____ Barbiturates _____ Sedatives _____ Iodine _____ Aspirin _____ Any Metals (e.g. nickel, mercury, etc.) _____ Latex Rubber _____ Other (please list) _____	
3. Are you taking any medication(s) including non-prescription medicine? _____ If yes, what medication(s) are you taking? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) _____	
4. Have you ever taken Fen-Phen/Redux? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	11. Women Only: a) Are you pregnant or think you may be pregnant? _____ b) Are you nursing? _____ c) Are you taking oral contraceptives? _____	
5. Do you use tobacco? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	12. Yes <input type="checkbox"/> No <input type="checkbox"/> Chest Pains _____ Easily Winded _____ Stroke _____ Hay Fever / Allergies _____ Tuberculosis _____ Radiation Therapy _____ Glaucoma _____ Recent Weight Loss _____ Liver Disease _____ Heart Trouble _____ Respiratory Problems _____ Mitral Valve Prolapse _____ Other _____	
6. Do you use controlled substances? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>		
7. Are you wearing contact lenses? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>		
8. Do you have or have you had any of the following?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
High Blood Pressure _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease _____	
Heart Attack _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Cardiac Pacemaker _____	
Rheumatic Fever _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur _____	
Swollen Ankles _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Angina _____	
Fainting / Seizures _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Frequently Tired _____	
Asthma _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia _____	
Low Blood Pressure _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Emphysema _____	
Epilepsy / Convulsions _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer _____	
Leukemia _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis _____	
Diabetes _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint Replacement or Implant _____	
Kidney Diseases _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis / Jaundice _____	
AIDS or HIV Infection _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Sexually Transmitted Disease _____	
Thyroid Problem _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	Stomach Troubles / Ulcers _____	

Patient Dental History

Name of Previous Dentist and Location _____	Date of Last Exam _____				
1. Do your gums bleed while brushing or flossing? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	8. Do you have frequent headaches? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	9. Do you clench or grind your teeth? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	10. Do you bite your lips or cheeks frequently? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Do you feel pain to any of your teeth? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	11. Have you ever had any difficult extractions in the past? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Have you had any head, neck or jaw injuries? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	13. Have you had any orthodontic treatment? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?		Yes <input type="checkbox"/> No <input type="checkbox"/>	14. Do you wear dentures or partials? _____ If yes, date of placement _____		Yes <input type="checkbox"/> No <input type="checkbox"/>
Clicking _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>
Pain (joint, ear, side of face) _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	16. Do you like your smile? _____		Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty in opening or closing _____		Yes <input type="checkbox"/> No <input type="checkbox"/>			
Difficulty in chewing _____		Yes <input type="checkbox"/> No <input type="checkbox"/>			

Authorization and Release

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 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

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

Signature _____

Date _____