

Welcome!

Thank you for choosing LifeSmile Dental Care. Please complete this form. If you have any questions we will be glad to help. (Please print)

PATIENT INFORMATION

Date: _____ Name _____ [] Dr. [] Mr. [] Mrs. [] Ms. [] Other: _____
First MI Last

Address _____ DOB: _____ [] Male [] Female

City _____ State _____ Zip _____ Home #(____) _____

Employer _____ Work #(____) _____ Cell #(____) _____

SSN#: _____ - _____ - _____ E-mail: _____ @ _____

Are you: [] Minor [] Married [] Single [] Divorced [] Widowed [] Separated Spouse's Name: _____

Spouse's Employer: _____ Spouse's Contact # (____) _____ [] Cell [] Work

Responsible Party (if different than patient)

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Contact#(____) _____ [] Cell [] Home

DOB ____/____/____ SSN# _____

Relationship: _____

About LifeSmile Dental Care:

Since 1982, LifeSmile Dental Care has been providing exceptional dental care for patients in the St. Louis area. Based on a deep, personal belief in the importance of each patient's dental health, our office pledges to provide the best dental care in a compassionate and friendly environment.

Our services include: general dentistry, cosmetic dentistry, Invisalign, implant restorations, same day crowns, teeth whitening and much more!

PREFERENCES

Do you prefer appointment reminders by: [] Email [] Phone [] Text

Do you prefer to receive calls from our office at: [] Home [] Cell [] Work

Whom may we thank for referring you: _____

How do you wish to be addressed by our staff: _____

INSURANCE INFORMATION

MEDIAL INSURANCE:

Subscriber's Name _____ DOB ____/____/____ Relationship to Patient _____

SSN# or ID# _____ Insurance Company _____ Policy # _____ Group # _____

DENTAL INSURANCE:

Subscriber's Name _____ DOB ____/____/____ Relationship to Patient _____

SSN# or ID# _____ Insurance Company _____ Policy # _____ Group # _____

Employer: _____ Employer Contact# (____) _____ Effect. Date ____/____/____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [] Yes [] No *If yes, please complete the following:*

Subscriber's Name _____ DOB ____/____/____ Relationship to Patient _____

SSN# or ID# _____ Insurance Company _____ Policy # _____ Group # _____

Employer: _____ Employer Contact# (____) _____ Effect. Date ____/____/____

CONFIDENTIAL

8430 PERSHALL RD~ HAZELWOOD, MO~ 63042

(314) 521-5678

MEDICAL HISTORY & CONSENT

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

ALLERGIES

Aspirin	Y	N
Barbiturates	Y	N
Codeine	Y	N
Erythromycin	Y	N
Jewelry	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Sedatives	Y	N
Sulpha	Y	N
Other	Y	N

List any other known Allergies:

CARDIOVASCULAR

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain	Y	N
Congenital Heart Defect	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
Heart Surgery	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N

ENDOCRINE

Diabetes	Y	N
Thyroid Problems	Y	N

EYES, EARS, NOSE & THROAT

Difficulty Swallowing	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillitis/Tonsillectomy	Y	N

GASTROINTESTINAL

Acid Reflux	Y	N
Ulcers	Y	N

GENERAL

Anemia	Y	N
Arthritis	Y	N
Cancer	Y	N
Colitis	Y	N
Fatigue/Tired	Y	N
Headaches (severe)	Y	N
Herpes/Fever Blisters	Y	N
HIV/AIDS	Y	N
Kidney Disease	Y	N
Knee/Hip Replacement	Y	N
Liver Problems	Y	N
Lupus	Y	N
Nursing	Y	N
Pregnant	Y	N
Recent Trauma/Injury	Y	N
Rheumatic/Scarlet Fever	Y	N
Radiation Treatment	Y	N
Shingles	Y	N
Venereal Disease	Y	N
Weight Change	Y	N

HEMATOLOGICAL

Bleeding Problems	Y	N
Blood Transfusion	Y	N
Hepatitis	Y	N
Hemophilia	Y	N
Blood Thinners	Y	N

ORAL/DENTAL

Bleeding Gums	Y	N
Dry Mouth	Y	N
Jaw Problems (TMJ)	Y	N
Clicking	Y	N
Pain	Y	N
Difficulty Swallowing	Y	N
Difficulty Chewing	Y	N
Ortho/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth Clenching	Y	N
Teeth Grinding	Y	N
Tooth Pain	Y	N
Wisdom Teeth Extraction	Y	N
Do you take antibiotics	Y	N
before dental procedures?	Y	N

MUSCULOSKELETAL

Back Pain	Y	N
Fibromyalgia	Y	N
Osteoporosis/Bisphosphonate Use	Y	N

NEUROLOGICAL

Alzheimer's Disease	Y	N
Dizziness/Fainting	Y	N
Epilepsy	Y	N
Memory Loss	Y	N
Multiple Sclerosis	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N

PSYCHIATRIC

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating Disorder	Y	N

RESPIRATORY

Asthma	Y	N
Bronchitis	Y	N
Breathing Problems	Y	N
Chest Pressure	Y	N
Emphysema	Y	N
Persistent Cough	Y	N
Tuberculosis	Y	N

SLEEP

Daytime Sleepiness	Y	N
Morning Headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N
Has anyone told you that you snore?	Y	N

SOCIAL HISTORY

Do you smoke?	Y	N
Do you use smokeless tobacco?	Y	N
Do you consume alcoholic beverage?	Y	N
_____ Drinks per day/week/month		
Do you use recreational drugs?	Y	N

Doctor Signature

Date

What is the reason for your dental visit today? _____

Previous/Present Dentist Name _____ Office Location _____

Office #: _____ Date of last dental exam: _____ Date of last dental x-rays: _____

Are you happy with the way your smile looks? [] Yes [] No If not, what would you change? _____

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HIPAA INFORMATION RELEASE AUTHORIZATION and ACKNOWLEDGEMENT

I, _____ authorize the release of ALL of my
(Patient Name)

HIPAA protected information to: _____ PH: () _____
(Spouse/Family Member Name) (Authorized Spouse/Family Member Phone)

- I understand that this includes financial, scheduling, and medical information.
- I understand that I may alter this declaration by submitting a written request.
- I also authorize the listed person(s) above to make scheduling, treatment, and financial arrangements on my behalf.

I authorize LifeSmile Dental Care to leave a message regarding any of my financial, scheduling, and/or medical information. @

PATIENT PHONE NUMBER: () _____ Home Mobile Work

I authorize LifeSmile Dental Care to email any of my financial, scheduling, and medical information. I understand my information will not be shared with any 3rd party providers.

PATIENT EMAIL: _____

I understand that I will still be financially responsible for any treatment performed, or products supplied to me.

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of LifeSmile Dental Care’s Privacy Policy (Notice) on the date indicated. If you have any questions regarding the information, please do not hesitate to contact a clinic representative or the LSDC Patient Privacy Officer as indicated on your Notice.

Patient Signature

Date

You have the right to review our privacy notice, to request restrictions and revoke consent, in writing, after you have reviewed our privacy notice.

OR

I do not wish to share any of my HIPAA protected information to anyone at this time

*** Please note - We must have this form on file before we can release any information to anyone other than the patient or legal guardian*