Edwards Lake Dental

cosmetic & family dentistry

First name: _____Last name:_____ Middle initial: _

Address:_____

City_____ State _____ Zip_____

Home Phone (____) _____Work Phone (____) _____

Cell Phone (____) _____

Circle appropriate response. **Male/ Female** Marital status: **Single/Married**

Date of Birth _____ SSN _____

Email Address: _____

Please **circle** your preferred way for us to contact you regarding your appointment reminders

Phone call Email Text message

Do you have dental insurance? **Yes/No**

If yes, please fill out next section completely

Are you the policy Holder? **YES /NO** If "NO" complete next section

Name of policy holder_____Birthdate _____

Address of policy holder_____

_____

SSN _____Employer_____

Please **circle** your relationship with the policy holder

Spouse, Child, Other _____

Insurance Company _____Group number _____

Contract Number_____

Edwards Lake Dental
cosmetic & family dentistry

Health History

Are you under the care of a physician now? Y or N _____

Have you had your eyes checked in the last 12 months?_____

You have any back problems that would prevent you from being in the dental chair? Y or N _____

Have you ever been hospitalized or had a major operation in the last 6 months? Y or N

_____

_____

Are you taking any medications? Please list, or allow us to copy a list

_____

_____

Do you use tobacco? Y or N Do you use controlled substances or illegal drugs? Y or N

For women: Are you pregnant/trying to get pregnant? Y or N Nursing? Y or N Taking oral contraceptives? Y or No

Are you allergic to anything?_____

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

Aids/HIV positive	Diabetes	Kidney problems
Alzheimer's Disease	Emphysema	Liver disease
Artificial heart valve	Seizures/epilepsy	Osteoporosis
Artificial Joint	Excessive bleeding	Pain in the jaw joints
Asthma	Genital herpes	Stroke
Breathing problems	Heart attack	Renal Dialysis
Bleeding problem	Pacemaker	Stroke
Blood disease	Heart trouble/heart disease	Thyroid disease
Blood transfusion	Hepatitis A	Are you currently on any Blood Thinners
Cancer/chemotherapy	Hepatitis B or C	
Chest pains	High blood pressure	

Have you ever had any serious illness not listed above?_____