Lassiter Family Dentistry

1891 Hwy. 40 East, Suite 1105 • Kingsland, GA 31548
Phone: (912) 576-4011 • Fax: (912) 729-5700

Patient Information (Confidential)

Thank You for Selecting Our Dental Team

To help us meet all your dental needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Name ______________________ **Date** ______________

SSN# ______________ **Birthday** ________ **Home Phone** ______________

Cell Phone ______________ **E-Mail** ______________

Address ______________ **City** ________ **State** ____ **Zip** ________

Check Appropriate Status: ❑ **Minor** ❑ **Single** ❑ **Married** ❑ **Separated** ❑ **Divorced** ❑ **Widowed**

If Student, are you: ❑ **Full Time** ❑ **Part Time**

Name of School/College ______________ **City** ________ **State** ____ **Zip** ________

Spouse or Parent/Guardian's Name ______________________

Person to Contact in Case of Emergency ______________ **Phone** ______________

Whom may we thank for referring you? ______________________

Responsible Party

Name of Person Responsible for this Account ______________________

SSN# ______________ **Birthday** ________ **Relationship to Patient** ______________

Home Address ______________ **City** ________ **State** ____ **Zip** ________

Home Phone ______________ **Cell Phone** ______________ **Work Phone** ______________

Employer/Company Name ______________________ **Date Employed** ______________

Business Address ______________ **City** ________ **State** ____ **Zip** ________

Insurance Company ______________ **Group#** ________ **Policy I.D.#** ________

Address ______________ **City** ________ **State** ____ **Zip** ________

For your convenience, we offer the following methods of payment.

❒ **Cash** ❒ **Personal Check** ❒ **Visa** ❒ **MasterCard** ❒ **Discover** ❒ **American Express**

LASSITER FAMILY DENTISTRY

DENTAL HISTORY

Patient Name ______________________ Nickname ______________ Age ______

Referred by ______________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist ______________________ How long have you been a patient? ______________ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ______________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY		YES	NO
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6.	Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐

GUM AND BONE		YES	NO
7.	Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐

TOOTH STRUCTURE		YES	NO
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT		YES	NO
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS		YES	NO
33.	Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	☐	☐
34.	Have you ever whitened (bleached) your teeth?	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature ______________________________ **Date** ____________

Doctor's Signature ______________________________ **Date** ____________

LASSITER FAMILY DENTISTRY

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ______________

Name of Physician ______________________ Date of Last Exam ______________ Physician Office Phone ______________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO
1. hospitalization for illness or injury	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin ☐ erythromycin		
☐ tetracycline ☐ sulfa		
☐ local anesthetic ☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver)______________		
☐ latex ☐ nuts		
☐ fruit ☐ other ______________		
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)	☐	☐
6. pacemaker or implantable defibrillator	☐	☐
7. orthopedic implant (joint replacement)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10. a stroke (taking blood thinners)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5)	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox	☐	☐
15. asthma	☐	☐
16. breathing or sleep problems (e.g., sleep apnea, snoring, sinus)	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c =)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia)	☐	☐
26. osteoporosis/osteopenia (e.g., taking bisphosphonates)	☐	☐
27. arthritis	☐	☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma	☐	☐
30. contact lenses	☐	☐
31. head or neck injuries	☐	☐
32. epilepsy, convulsions (seizures)	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34. viral infections and cold sores	☐	☐
35. any lumps or swelling in the mouth	☐	☐
36. hives, skin rash, hay fever	☐	☐
37. STI/STD/HPV	☐	☐
38. hepatitis (type ___)	☐	☐
39. HIV/AIDS	☐	☐
40. tumor, abnormal growth	☐	☐
41. radiation therapy	☐	☐
42. chemotherapy, immunosuppressive medication	☐	☐
43. emotional difficulties	☐	☐
44. psychiatric treatment	☐	☐
45. antidepressant medication	☐	☐
46. alcohol/recreational drug use	☐	☐

ARE YOU:

	YES	NO
47. presently being treated for any other illness	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea)	☐	☐
49. taking medication for weight management	☐	☐
50. taking dietary supplements	☐	☐
51. often exhausted or fatigued	☐	☐
52. experiencing frequent headaches	☐	☐
53. a smoker, smoked previously or use smokeless tobacco	☐	☐
54. considered a touchy/sensitive person	☐	☐
55. often unhappy or depressed	☐	☐
56. taking birth control pills	☐	☐
57. currently pregnant	☐	☐
58. diagnosed with a prostate disorder	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) ______________________

List all medications, supplements, and or vitamins taken within the last two years: ______________________

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

ACKNOWLEDGMENT 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 PATIENTS NAME)

Signature: ______________________ **Date:** ______________

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please specify) ______________________

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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 service rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) ______________________