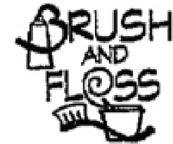
Welcome to the Office of Legacy Hill Dentistry

Please Print



Today's Date:___________

Patient's Full Name:________________________ **Age:**________________________

Address:________________________ **Birthday:**____________________

________________________ **Social # :**____________________

________________________ **Status:** Married Single Child Other

Patient/Parent Employer:________________ **Employer Ph #:**________________

Parent/Spouse's Name: ________________ **Birthday:**____________________

Employer:________________________ **Social #:**____________________

Email: ________________________

How did you hear about our office? ____________________________________

Patient's Home Ph #:________________________ **Cell #:**____________________

Work Phone #: ________________ **Ext:**_____

In Case of Emergency, Please Contact: ________________________________

Relationship: ________________________ **Phone #:** ________________

Who is responsible for this account?________________________________

Primary Ins Co. :________________________ **Subscriber:**________________

Subscriber's Social :____________________ **Birthday:** ________________

Employer: ________________________ **Group #:** ________________

Is patient covered by a second insurance company? Y or N

Sec Ins Co. : ________________________ **Subscriber:** ________________

Subscriber's Social : ________________ **Birthday:** ________________

Employer: ________________________ **Group # :** ________________

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with ____________________ and assign directly to Legacy Hill Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ________________________ **Date:** ___________

Relationship to patient: ________________________

Acknowledgement of receipt of Notice of Privacy Practices:
I have received a copy of this office's Notice of Privacy Practices.
Signature: ______________________________ **Date:**_______

Please list all parties/persons we can share your treatment or personal information with:
____

Dental History:

Reason for today's visit:______________________
____
Date of last dental visit: ______________________

Former Dentist: ______________
City/State: ______________
Last x-rays: ______________

Please answer the following:

Bad Breath	**Y or N**	**Orthodontic Treatment**	**Y or N**
Bleeding Gums	**Y or N**	**Pain around ear**	**Y or N**
Blisters on lips or mouth	**Y or N**	**Periodontal Treatment**	**Y or N**
Burning Tongue	**Y or N**	**Sensitivity**	**Y or N**
Chew on one side of mouth	**Y or N**	**Sores or growths in mouth**	**Y or N**
Grinding Teeth	**Y or N**	**Tobacco Use**	**Y or N**
Jaw Pain	**Y or N**	**Clicking or popping jaw**	**Y or N**
Lip or cheek biting	**Y or N**	**Dry Mouth**	**Y or N**
Loose teeth/broken fillings	**Y or N**	**Fingernail Biting**	**Y or N**
Mouth Breathing	**Y or N**	**Food collection between teeth**	**Y or N**
Mouth Pain	**Y or N**		

How often do you floss? ____________ How often do you brush? ____________

Do you like your smile? ____________ What would you change? ____________

Please list any and all medications that you are currently taking:

____

____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen"? These include combinations of Ionimin, Adipex, Fastin (brand names), Pondimin (Fenfluramine) and Redux (Dexfenfluramine) **Y or N**

Are you taking prescription medication for Osteoporosis? Y or N

If yes, What is the name of your medication?______________________

Who is your current Physician? ____________________ Phone #: _______________

Health History:

AIDS/HIV	Y or N	Epilepsy	Y or N	Radiation Treatment	Y or N
Anemia	Y or N	Fainting/Dizziness	Y or N	Respiratory Disease	Y or N
Arthritis	Y or N	Glaucoma	Y or N	Rheumatic Fever	Y or N
Artificial Heart Valves	Y or N	Headaches	Y or N	Scarlet Fever	Y or N
Artificial Joints	Y or N	Heart Murmur	Y or N	Shortness of Breath	Y or N
Asthma	Y or N	Heart Problems	Y or N	Sinus Trouble	Y or N
Back Problems	Y or N	Hepatitis Type ____	Y or N	Skin Rash	Y or N
Abnormal Bleeding	Y or N	Herpes	Y or N	Special Diet	Y or N
Blood Disease	Y or N	High Blood Pressure	Y or N	Stroke	Y or N
Cancer	Y or N	Jaundice	Y or N	Swollen Feet/Ankles	Y or N
Chemical Dependency	Y or N	Jaw Pain	Y or N	Swollen Neck Glands	Y or N
Chemotherapy	Y or N	Kidney Disease	Y or N	Thyroid Problems	Y or N
Circulatory Problems	Y or N	Liver Disease	Y or N	Tonsillitis	Y or N
COPD	Y or N	Low Blood Pressure	Y or N	Tuberculosis	Y or N
Congenital Heart Lesions	Y or N	Lupus	Y or N	Tumor/Growth	Y or N
Cortisone Treatments	Y or N	Mitral Valve Prolapse	Y or N	Ulcer	Y or N
Persistent/Bloody Cough	Y or N	Nervous Problems	Y or N	Venereal Disease	Y or N
Diabetes	Y or N	Pacemaker	Y or N	Weight Loss	Y or N
Developmental Delays	Y or N	Psychiatric Care	Y or N		
Emphysema	Y or N	Other: ____________________			

Women: Are you pregnant? Y or N If yes, Due Date: ____________ OBGYN: ______________

Taking Birth Control Pills? Y or N Are you nursing? Y or N

Allergies:

Aspirin	Y or N	Local Anesthetic	Y or N	Barbiturates	Y or N
Codeine	Y or N	Penicillin	Y or N	Sulfa	Y or N
Iodine	Y or N	Latex	Y or N	Other: ______________	

All of the above information is true and accurate to the best of my knowledge.

Completed By: ______________________________ **Date:** ________________

By signing below I fully understand that Legacy Hill Dentistry has a no show policy. Within a 24 month period your first no show/cancellation less than 24 hours prior will be a warning, and your second no show/cancellation less than 24 hours prior will be a $50.00 charge per hour for your missed appointment. This is per patient policy, NOT per family.

X____