

WELCOME

PATIENT INFORMATION

Date 01/31/2024
SS/HIC/Patient ID # _____
Last Name _____
First Name _____
Address _____
City _____
State/Zip _____ / _____
E-mail _____
Sex M F Age _____
Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Occupation _____
Patient Employer/School _____
Employer/School Address _____

Employer/School Phone _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you?

PHONE NUMBERS

Home _____
Work _____
Cell _____
Spouse's Work _____
Best time and place to reach you

IN CASE OF EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name _____
Relationship _____
Phone _____

DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____
Date of last dental visit _____

DENTAL INSURANCE

Who is responsible for this account? _____
SS/ID # _____
Patient's Relationship to Responsible Party
 Self Spouse Child
Insurance Co. _____
Insurance Phone _____
Group #: _____
Is patient covered by additional insurance? Yes No
Subscriber's Name _____
Birthdate _____
SS/ID # _____
Patient's Relationship to Subscriber
 Self Spouse Child
Insurance Co. _____
Insurance Phone _____
Group #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

Name of Insurance Company(ies)

and assign directly to Lorven Dental 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 authorize the use of my signature on all insurance submissions.

Lorven Dental may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Name of Patient, Parent, Guardian or Personal Representative

01/31/2024

Date

Relationship to Patient

City/State _____
Date of last dental X-rays _____

HEALTH HISTORY

Physician's Name _____

Date of last visit _____

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 of phentermine),
 Pondimin (fenfluramine) and Redux (dexfenfluramine).

Yes No

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash
<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Abnormally, with extractions or surgery	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Feet or Ankles
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands
<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or Growth on head or neck
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss, unexplained
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment			

Do you wear contact lenses? Yes No

Women: Are you pregnant? Yes No

Are you nursing? Yes No

Due Date: _____

Taking birth control pills? Yes No

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Pharmacy Phone _____

ALLERGIES

Aspirin

Barbiturates (Sleeping pills)

Codeine Other (list below)

Iodine

Latex

Local Anesthetic

Penicillin

Sulfa

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.