Patient Registration Form

Lakeland Creek Family Dental
8080 Utah Street
Merrillville, IN 46410

Name	Sex: M F	Birth date:	Today's Date:
Home Address	City	State	Zip
Previous Address	City	State	Zip
Please Circle one: Single married separated widowed	Occupation		Home Phone:
Your Employer	How Long?	SS#	Work Phone:
Are you a full time student? ❑Yes ❑No	If patient is minor: Mother's Birth date:		Father's Birth date:
Name of Spouse (Parent if Minor):	Email:		Cell Phone:
Spouse's (Parent's) Employer:	Spouse(Parent's) SS#:		Work Phone
Referred to us by:	Name, Address, & Telephone of		
Reason for visit:	Relative not living with you		

Dental Insurance Information (Primary Carrier)			**Complete this for Secondary Coverage**		
Insured's Name	DOB:	SS#	Insured's Name	DOB:	SS#
Insured's Employer			Insured's Employer		
Insurance Co.			Insurance Co.		
Insurance Co Address			Insurance Co Address		
Phone No			Phone No		
Group #	Local #		Group #	Local #	

It is important that we know about your Medical and Dental History. These facts have direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Medical History	Yes	No	If yes, Explain
Do you have any current health problems?	❑	❑	
Are you under a Physician's care now?	❑	❑	
Are you currently taking any medications	❑	❑	

PLEASE CHECK YES OR NO

	Yes	No		Yes	No		Yes	No
Aids	❑	❑	Excessive Bleeding	❑	❑	Pacemaker	❑	❑
Anemia	❑	❑	Fainting	❑	❑	Phen Fen(if taken > 1 month)	❑	❑
Allergies	❑	❑	Glaucoma	❑	❑	Pregnant-currently	❑	❑
Angina Pectoris	❑	❑	Hay Fever	❑	❑	Psychiatric Treatment	❑	❑
Arthritis	❑	❑	Heart Disease/Attack	❑	❑	Radiation Treatment	❑	❑
Artificial Heart Valve	❑	❑	Heart Murmur	❑	❑	Respiratory Problem	❑	❑
Artificial Joints	❑	❑	Heart Surgery	❑	❑	Rheumatism	❑	❑
Asthma	❑	❑	Hepatitis A	❑	❑	Scarlet Fever	❑	❑
Blood Disease	❑	❑	Hepatitis B	❑	❑	Sinus Problems	❑	❑
Bruise Easily	❑	❑	High Blood Pressure	❑	❑	Stomach Problems	❑	❑
Cancer	❑	❑	HIV Positive	❑	❑	Stroke	❑	❑
Chemotherapy	❑	❑	Jaundice	❑	❑	Thyroid Disease	❑	❑
Congenital Heart Lesions	❑	❑	Jaw Joint Pain	❑	❑	Tuberculosis	❑	❑
Dizziness	❑	❑	Kidney Disease	❑	❑	Ulcers	❑	❑
Diabetes	❑	❑	Liver Disease	❑	❑	Venereal Disease	❑	❑
Drug Addiction	❑	❑	Low Blood Pressure	❑	❑	Other__________	❑	❑
Emphysema	❑	❑	Mitral Valve Prolapse	❑	❑		❑	❑
Epilepsy	❑	❑	Nervous Disorder	❑	❑	If Pregnant-Due Date ________		

Are you allergic or have you reacted adversely to any of the following medications?

	Yes	No		Yes	No		Yes	No
Aspirin	❑	❑	Percodan	❑	❑	Erythromycin	❑	❑
Darvon	❑	❑	Local Anesthetic	❑	❑	Valium	❑	❑
Nitrous Oxide	❑	❑	Codeine	❑	❑	Penicillin	❑	❑
						Other __________		

Family Physician______________________ Phone Number____________________

Is there any other medical or dental information that you feel I should know about?

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CONSENT FOR TREATMENT: The undersigned hereby authorizes Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. The above information provided is an accurate representation of my health and all prescription medicines are listed. I understand that dental treatment in and of it self embodies a certain risk and that additional treatment other than what initially prescribed may be required to help save my teeth.

PATIENT Signature (Parent of Child) ______________________ Date: ______________ DENTIST Signature ______________