

Thank you tor selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

PRA	CTICE	Cell Phone #
MARK LAMBERT, D.D.S.		Soc. Sec. #
PATIENT INFORMATION (CONFIDENTIAL)		Date
Name	Birthdate	Home Phone
Address	City	State Zip
Check Appropriate Box: ☐ Minor ☐ Single	gle 🗌 Married 🔲 Divorced 🔲 Widow	ed Separated
If Student, Name of School / College	City	State Full Part
Patient's or Parent's Employer		
Business Address	City	State Zip
Spouse or Parent's Name	Employer	Work Phone
Whom May We Thank for Referring You?		
Person to Contact in Case of Emergency_		Phone
RESPONSIBLE PARTY		Relationship
Name of Person Responsible for this Accou	int	
Address		Home Phone
Driver's License #	BirthdateEmail	ail Address
Employer	Work Phone	SS#
INSURANCE INFORMATION Name of Insured	essa i serien	Relationship to Patient
Birthdate Social S	Security #	
Name of Employer		
Address of Employer		
Insurance Company		
Ins. Co. Address		
How Much is your Deductible?		
DO YOU HAVE ANY ADDITIONAL	INSURANCE? ☐ Yes ☐ No IF YES, CC	MPLETE THE FOLLOWING:
Name of Insured	English (2)	Relationship to Patient
Birthdate Social S		ate Employed
Name of Employer		
Address of Employer	City	State Zip
Insurance Company	Group #	Policy/ID#
Ins. Co. Address	City	State Zip
How Much is your Deductible?	How Much Have You Used?	Max. Annual Benefit?

PATIENT MEDICAL HISTORY Office Phone Date of Last Exam Physician Yes No No 9. Are you allergic to or have you had any reactions 1. Are you under medical treatment now? to the following? 2. Have you ever been hospitalized for any surgical Local Anesthetics (eg. Novocaine)..... operation or serious illness within the last 5 years? ... Penicillin or any other Antibiotics..... If yes, please explain_ Sulfa Drugs..... Barbiturates 3. Are you taking any medication(s) including Sedatives..... non-prescription medicine? lodine..... If yes, what medication(s) are you taking? Aspirin Any Metals (e.g. nickel, mercury, etc.)..... Latex Rubber Have you ever taken Phen-Fen/Redux?..... Other (please list) ___ Do you use tobacco?..... 10. Women Only: Do you use alcohol? How much? a) Are you pregnant or think you may be pregnant? Are you wearing contact lenses? b) Are you nursing?..... c) Are you taking oral contraceptives?..... 8. Do you have or have you had any of the following? Yes No Yes No Yes No High Blood Pressure Heart Disease..... Chest Pains Heart Attack..... Cardiac Pacemaker..... Easily Winded..... Rheumatic Fever Heart Murmur..... Stroke Swollen Ankles..... Angina Hay Fever / Allergies Frequently Tired..... Tuberculosis..... Fainting / Seizures..... Asthma Radiation Therapy Anemia Low Blood Pressure Glaucoma..... Emphysema..... Epilepsy / Convulsions Cancer..... Recent Weight Loss Leukemia..... Arthritis Liver Disease..... Heart Trouble Joint Replacement or Implant Diabetes Hepatitis / Jaundice Respiratory Problems..... Kidney Disease..... Sexually Transmitted Disease..... Mitral Valve Prolapse..... AIDS or HIV Infection Stomach Troubles / Ulcers..... Other..... Thyroid Problem PATIENT DENTAL HISTORY Date of Last Exam Name of Previous Dentist and Location Yes No Difficulty in chewing 1. Do your gums bleed while brushing or flossing? Yes No 2. Do you feel pain to any of your teeth? 6. Do you have frequent headaches? 3. Do you have any sores or lumps in or near your mouth? 7. Do you clench or grind your teeth?..... 8. Have you ever had any prolonged bleeding 4. Have you had any head, neck or jaw injuries?..... following extractions? 5. Have you ever experienced any of the following 9. Have you had any orthodontic treatment? problems in your jaw? 10. Have you ever received oral hygiene instructions Clicking regarding the care of your teeth and gums?..... Pain (joint, ear, side of face) 11. Do you like your smile? Difficulty in opening or closing LOCAL ANESTHETICS (NOVOCAINE): I understand that I may be given a local anesthetic injection and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment. I understand that as a result of being given a local anesthetic injection (eg: novocaine) my mouth, tongue, lips, or face may become temporarily or permanently numb or bruised. Patient Signature:

AUTHORIZATION AND RELEASE

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 services rendered on my behalf or my dependents.