



April 25, 2007

Dear Patient,

We are pleased to welcome you to our family of patients. Thank you for selecting our office to evaluate and care for your dental needs. We are dedicated to providing the best possible dental care in a comfortable, caring environment.

During your first visit, a thorough oral examination will be completed. This will include radiographs and other diagnostic aids necessary to determine indicated dental treatment.

In order to evaluate your dental health thoroughly, please complete both sides of the enclosed questionnaire and return it to our office in the enclosed envelope PRIOR to your appointment.

Should you have any questions, please call our office at your convenience. We look forward to meeting you.

Sincerely,

Dr. Dennis Lucas

# WELCOME

**Dennis R. Lucas, D.M.D.**

**Our goal is to help you reach and maintain maximum oral health. You will be provided with an office brochure so that we may better serve you. Thank you for filling out this form completely.**

## ABOUT YOU

Today's Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Name: \_\_\_\_\_

I like to be called: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Mailing Address, if different: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Your Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Special interests, sports or hobbies: \_\_\_\_\_  
\_\_\_\_\_

Referred by: \_\_\_\_\_

## DENTAL INSURANCE

Do you have dental insurance through your employer?

Yes \_\_\_ No \_\_\_

If yes, please provide the following information:

Dental Insurance Co. #1: \_\_\_\_\_

Group #: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Your Employer's Name: \_\_\_\_\_

Do you have any other Dental Insurance Coverage?

Yes \_\_\_ No \_\_\_

This coverage is through:

Spouse \_\_\_ Parent \_\_\_ Other \_\_\_

Their Name: \_\_\_\_\_

Their Employer's Name: \_\_\_\_\_

Their Social Security #: \_\_\_\_\_

Their Birthdate: \_\_\_\_\_

Dental Insurance Co. #2: \_\_\_\_\_

Group #: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

## TELEPHONE

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

When is the best time to reach you? \_\_\_\_\_

Where? \_\_\_\_\_ Specific days? \_\_\_\_\_

In the event of an emergency, is there someone who lives near you that we could contact?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work #: \_\_\_\_\_ Home #: \_\_\_\_\_

# MEDICAL HISTORY

Do you have a personal physician? Yes \_\_\_\_\_ No \_\_\_\_\_

Their Name: \_\_\_\_\_

Their Phone #: \_\_\_\_\_

The approximate date of your last visit: \_\_\_\_\_

Your current physical health is:

Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Are you currently under the care of any physician or dentist?

Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you presently taking any drugs prescribed by a physician or dentist? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list: \_\_\_\_\_

\_\_\_\_\_

For women: Are you pregnant? No \_\_\_\_\_ Yes \_\_\_\_\_ Wk# \_\_\_\_\_

Do you need to be premedicated before dental treatment?

Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had any serious medical problems in the last 5 years?

No \_\_\_\_\_ Yes \_\_\_\_\_, please explain \_\_\_\_\_

\_\_\_\_\_

Have you ever had any of these diseases or medical problems?

|                               |                              |
|-------------------------------|------------------------------|
| Y N Heart Failure             | Y N Artificial Joints        |
| Y N Heart Disease or Attack   | Y N Kidney Problems          |
| Y N Angina Pectoris           | Y N Ulcers                   |
| Y N Congenital Heart Disease  | Y N Diabetes                 |
| Y N Heart Murmur              | Y N Thyroid Problems         |
| Y N High/Low Blood Pressure   | Y N Glaucoma                 |
| Y N Arteriosclerosis          | Y N Cosmetic Surgery         |
| Y N Mitral Valve Prolapse     | Y N Emphysema                |
| Y N Artificial Heart Valve    | Y N Chronic Cough            |
| Y N Heart Pacemaker           | Y N Tuberculosis (TB)        |
| Y N Heart Surgery             | Y N Asthma                   |
| Y N Rheumatic Fever           | Y N Hay Fever                |
| Y N Arthritis                 | Y N Allergies or Hives       |
| Y N Rheumatism                | Y N Sinus Trouble            |
| Y N Cortisone Medicine        | Y N Radiation Therapy        |
| Y N Drug Addiction            | Y N Chemotherapy             |
| Y N Stroke                    | Y N Hepatitis A (infectious) |
| Y N Venereal Disease          | Y N Hepatitis B (serum)      |
| Y N Cold Sores/Fever Blisters | Y N AIDS or HIV Positive     |
| Y N Blood Transfusion         | Y N Hemophilia               |
| Y N Bruise easily             | Y N Anemia                   |
| Y N Liver Disease             | Y N Sickle Cell Anemia       |
| Y N Yellow Jaundice           | Y N Epilepsy or Seizures     |
| Y N Nervousness               | Y N Fainting or Dizzy Spells |
| Y N Psychiatric Treatment     | Y N Developmentally Disabled |

Any other serious medical conditions:

Have you experienced any that are not listed above?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Are you allergic to or have you ever reacted adversely to any medication or substance? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list: \_\_\_\_\_

**I** understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# CONSENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photograph, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_

\_\_\_\_\_ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agree upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received within 30 days, I understand that a 1 1/2% late charge (18% APR) may be added to my account. In the event my account becomes delinquent 60 days, I understand that a billing charge of \$3.00 may be added to my account.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Parent or Responsible Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

*Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA and the ADA.*

# Consent for Purposes of Treatment, Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information by Dennis R. Lucas, D.M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Dennis R. Lucas, D.M.D.. I understand that diagnosis or treatment of me by Dennis R. Lucas, D.M.D. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dennis R. Lucas, D.M.D. is not required to agree to the restrictions that I may request. However, if Dennis R. Lucas, D.M.D. agrees to a restriction that I request, the restriction is binding on Dennis R. Lucas, D.M.D..

I have the right to revoke this consent, in writing, at any time, except to the extent that Dennis R. Lucas, D.M.D. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Dennis R. Lucas, D.M.D.'s Notice of Privacy Practices prior to signing this document. The Dennis R. Lucas, D.M.D.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Dennis R. Lucas, D.M.D.. The Notice of Privacy Practices for Dennis R. Lucas, D.M.D. is also provided **in the reception area posted on the wall**. This Notice of Privacy Practices also describes my rights and the Dennis R. Lucas, D.M.D.'s duties with respect to my protected health information.

Dennis R. Lucas, D.M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority