

WELCOME

It is our goal is to help you reach a happy, healthy smile and maintain maximum oral health.

Please fill out this form completely.

	Date:		
Patient Ir	formation		
Full Name:	Prefer to be called:		
	Single Married Divorced Widowed		
Birthdate: / / Age: SS #:	Email:		
Address:			
STREET Cell #: ()	APT/CONDO # CITY STATE ZIP Wk #: ()		
Where & when best times to reach you?	Other family members seen by us?		
Emp. Address:			
STREET	SUITE # CITY STATE ZIP		
How long there? Whom may we Thank fo			
Current Dentist: Date of last visit			
Spouse or Par	ent Information		
Name: Relationship:	Birthdate: / / SS#:		
Employer:	Wk #: () Cell #: ()		
In the event of an emergency, is there someor	ne who lives near you that we should contact?		
Name: Relationship:	Wk #: () Hm / Cell #: ()		
	Ince Coverage		
Primary Dental Coverage	Secondary Dental Coverage		
Ins. Co. Name:	Ins. Co. Name:		
Ins. Co. Address:	Ins. Co. Address:		
Ins. Co. Phone #: () Ins. Co. Phone #: ()			
Group # (Plan, Local or Policy #): Group # (Plan, Local or Policy #):			
Subscriber Name: Subscriber Name:			
Birthdate: / / ID#:	Birthdate: / / ID#:		
Relationship to patient:	tient: Relationship to patient:		
Subscriber Employer:	Subscriber Employer:		



DENTAL/MEDICAL HISTORY INFORMATION

Page	2	of	4

Dental Impans & Periodonics Dette: Dental History Dette: Reason for today's visit? Do you like your smile? Your current dental health is: Good Fair Poor Are you currently in pain? For how long? Have you had a serious / difficult problem associated with previous dental work? Please indicate any of the following problems by checking off the corresponding box: Stained teath Disconfort, clicking or popping in Jaw CostPiroken filling(s) Difficulty opening or closing Jaw Prob settere netrylums when pressed Reading teath Blad breath Bitscenstores in or around mouth Burning tongue/lips Bioceent infections or sore throat Field denture Prolonged bleeding from injuny/extraction Receding gums Receding gums Receding gums Field denture My teeth are sensitive to: How often do you? Toothbrush type: Deteit (Medium Pland Biting Bush: Waterpik: Are you under the care of a physician? Phone #: () Address: Date of last visit: / / Do you smoke or use tobacco? Type: How much: How long: List any history of serious medical c		n Board of Periodontology	Name:			
Reason for today's visit? Do you like your smile? Your current dental health is:GoodFairPoor Are you currently in pain? For how long? Have you had a serious / difficult problem associated with previous dental work? Please indicate any of the following problems by checking off the corresponding box:	Dental Implants & T	CHOUDINICS	Dat	te:		
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Image: Constraint of the second se		-				
Eye disease / Glaucoma Bleeding tendency / Hemophilia Swollen ankles Abnormal bleeding	-		—			
	-			-		
		Cancer/Radiation/Chemotherapy	Are you on a diet?	Venereal disease		
Hay fever / Sinus problems Artificial knee or hip joint Frequent headaches HIV / AIDS			-			

DENTAL/MEDICAL HISTORY INFORMATION

	Lisa A. Lear, DDS, MSD
	Diplomate American Board of Periodontology Dental Implants & Periodontics

Name:

Page 3 of 4

Dentar implan	nts & Periodontics			Date:	
		Medications	& Allergies		
Blood Thinners (Advil, As	pirin)	relaxers ☐Sti nel, Aredia, Boniva, vix, Eliquis, Pradaxa	mulants Tranquilizers Didronel, Fosamax, Prolia, F a, Xarelto) tural, herbal or homeop	eclast, Zometa)	☐ None ☐ Antidepressants
Medication	Dosage	Frequency	Medication	Dosage	Frequency
Are you allergic to, or had a reaction to the following? Image: Control of the following? Penicillin / Amoxicillin Aspirin Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Control of the following? Image: Contro of the following? Image: Control of the					
List any other medicatio			List any other aller		
	Hooltha	ara Spacialia	ts / Dental Specialist		
Name	Phone		Condition / Trea		
Hunc	() () ()				
	()				
	()				
For Women					
Are you pregnant?		If Yes, # of week		ursing?	s 🔲 No
Are you using a prescribed (Note: Antibiotics may alter e			No our physician for assistance re	egarding additional t	pirth control methods

DENTAL/MEDICAL HISTORY INFORMATION

Page 4 of 4



Name:

Date:

		Dale.	
General Aut	horization & Financial Con	sent	
I certify that I have read and I understand the questions above. I acknowledge that my questions, if any about the inquiries set forth above have been answered to my satisfaction. 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. I will not hold my doctor, or any member of his/her staff, responsible for any errors or omissions that I have made in the questionnaire above.			
I authorize the doctor and dental staff to perform any my informed consent.	necessary dental services that is need	led during diagnosi	s and treatment with
I authorize the office of Dr. Lear to release any inform and my dependent(s) to third party insurance carriers		of treatment of exc	mination for myself
I grant my permission to telephone me or the listed pe consent, my treatment, or my account. If your contac			
Name:	Relationship:	Phone #: ()
Name:	Relationship:	Phone #: ()
I understand that I am financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). This dental office cannot render services on the assumption that our fees will be paid by an insurance company. As a courtesy, we will file your insurance claims and have your insurance company reimburse you directly. In the event of legal action on this account, I agree to pay any and all costs of such suit, collection and attorney fees. I have read the above authorizations, conditions of treatment and payment and agree to their content.			
Signature of patient (Guardian, Representative or Par	ent if Minor) Dat	1	
I give permission for any photos of my mouth taken b	y the office of Dr. Lear to be used for	educational and pro	omotional purposes.
Signature of patient (Guardian, Representative or Par	ent if Minor) Dat	2	
Ins	surance Authorization		
If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. The signature on file is my authorization for the release of information necessary to process my claim.			
Signature of patient (Guardian, Representative or Par	ent if Minor) Dat		
HIPAA Acknowledgement			
I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me and I may ask for a copy to take with me at any time. I have been given the opportunity to ask questions I may have now or in the future regarding the Notice.			
Signature of patient (Guardian, Representative or Par	ent if Minor) Dat	2	
Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.			
DOCTOR USE ONLY			
I verbally reviewed the medical / dental information above with the patient named herein. Initials: Date:			
Doctor's Comments:			
FORM DMH2023			