RYAN J. LANMAN, DDS, MSD, PC

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NEW PATIENT INFORMATION

DATE _____

NAME Mr. Mrs. Miss / Dr. Ms. Rev. _____ SOC. SEC. #_____

HOME ADDRESS _____ HOME PHONE ( ) _____
Street City State Zip

E-MAIL ADDRESS _____ CELL PHONE ( ) _____

OCCUPATION _____ EMPLOYER _____

BUSINESS ADDRESS _____ BUS. PHONE ( ) _____

AGE_____ DATE OF BIRTH_____ SEX _____ HEIGHT _____ WEIGHT_____

MARITAL STATUS: _____ MARRIED _____SINGLE _____WIDOWED/WIDOWER _____ DIVORCED

SPOUSE'S NAME_____ DATE OF BIRTH _____ SOC. SEC. #_____

SPOUSE'S EMPLOYER _____ BUS. PHONE ( ) _____

SPOUSE'S BUSINESS ADDRESS _____

PERSONS TO CONTACT IN CASE OF EMERGENCY:

1._____ RELATIONSHIP _____ PHONE ( ) _____

2._____ RELATIONSHIP _____ PHONE ( ) _____

PERSON RESPONSIBLE FOR ACCOUNT _____ **RELATIONSHIP** _____

REFERRED BY _____ **GENERAL DENTIST** _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE CARRIER _____ **POLICY #** _____

SUBSCRIBER'S NAME _____ DATE of BIRTH _____ SOC. SEC. # _____

SUBSCRIBER'S EMPLOYER_____

SECONDARY DENTAL INSURANCE CARRIER _____ **POLICY #** _____

SUBSCRIBER'S NAME _____ DATE of BIRTH _____ SOC. SEC. # _____

CURRENT DENTAL CONDITION

YES NO 1. Are you in pain?
YES NO 2. Do you have trouble chewing or speaking?
YES NO 3. Are you unhappy with the appearance of your teeth or smile?
YES NO 4. Additional comments: _____

PAST DENTAL HISTORY

1. How long have you been under the care of your current dentist? _____
2. When was your last dental visit?_____Reason for that visit? _____
3. Describe any previous periodontal treatment_____
4. Please list any additional information regarding your dental history about which you feel we should be aware _____

_____

Please continue on reverse side

MEDICAL HISTORY

1. Please describe your current physical health Good Fair Poor
2. Please list your current physician(s):
   a. _____ Phone ( ) _____
   b. _____ Phone ( ) _____
3. How often do you see your physician? _____
4. Date of last complete physical examination _____ Did it include: ____ Bloods Test ____EKG
5. Circle any of the following you have had, or have at present:

Heart Disease or Attack (Year _____)	Emphysema	HIV Positive
Angina Pectoris	Tuberculosis (TB)	AIDS
High Blood Pressure	Asthma	Hepatitis- A B C
Low Blood Pressure	Hay Fever	Liver Disease
Heart Murmur	Sinus Trouble	Blood Transfusion (Year_____)
Mitral Valve Prolapse	Allergies or Hives	Hemophilia
Artificial Heart Valve	Diabetes- Type I Type II	Drug or Alcohol Addiction
Heart Pacemaker	Thyroid Disease	Epilepsy or Seizures
Heart Surgery	Cancer	Fainting or Dizzy Spells
Artificial Hip / Knee Joint (Year _____)	Radiation / Chemotherapy	Nervousness
Anemia	Arthritis	Ulcers
Sickle Cell Disease	Cortisone Medication	Pain in Jaw Joints
Unusual Bruising or Bleeding	Glaucoma	Anxiety, Emotional or Stress-Related
Stroke	Kidney Infection or Disease	Therapy

6. Current Medications: _____
   _____
7. Please indicate any medications to which you may be allergic:
   Penicillin Erythromycin Codeine Aspirin Others: _____
   Tetracycline Keflex Demerol Tylenol _____
8. Do you require pre-medication with antibiotics prior to dental visits? If so, which antibiotic?_____
9. Please list any major operations: _____
   _____

YES NO 10. Do you smoke cigarettes or use Nicotine products (such as a Nicotine patch, snuff, smokeless tobacco, etc.)? How much?_____ How long?_____

YES NO 11. Do you drink alcoholic beverages? Average drinks per week _____

YES NO 12. Do your ankles swell during the day?

YES NO 13. Have you had significant unexplained change in weight in the past year?

YES NO 14. Do you ever wake up from sleep short of breath?

YES NO 15. Are you on a special diet? Comments: _____

YES NO 16. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath or because you are very tired?

YES NO 17. Do you have any disease, condition, or problem not listed? If yes, comment _____
_____

WOMEN

YES NO 18. Are your pregnant

YES NO 19. Are your taking birth control pills or hormone supplements?

YES NO 20. Have you reached menopause?

Consent for Treatment for _____
(Please print patient's name)

I attest that, to the best of my knowledge, the information provided on this form is accurate and complete. I am responsible for reporting any change in health status or medications to the Doctor at the next dental visit following the change. I authorize the Doctor or his representative to obtain appropriate health care information from other health care providers as necessary for diagnosing, treating, or insurance filing purposes. I also authorize the Doctor or his representative to use or disclose my personal health information only as necessary for the purpose of treatment, payment or health care operations.

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine and I agree to pay all fees and charges for such treatment. Fees are due and payable at the time services are rendered unless other arrangements have been made in advance with the Doctor's staff.

SIGNED _____ **DATE**_____
☐ Patient ☐ Parent ☐ Guardian