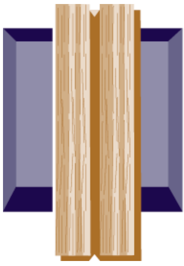

LAURENCE H. STONE, D.D.S.

COSMETIC & GENERAL DENTISTRY

For the smiles of your life.

We are complimented that you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office? ______________________________

Patient Information

Date ______________

Patient's Last Name ______________________ First Name ______________________ MI______

Complete Address ____

Home Phone ________________ Work ________________ Cell________________

Patient's Social Security # ______________________ Email ______________________

If patient is a minor, give parent/guardian's name ______________________________

Emergency Contact Name/Relationship ______________________________

Responsible Party Information

Last Name ______________________ First ______________________ MI ________

Billing Address ____

Home Phone ________________ Work ________________ Cell ________________

Social Security # ______________________________ DOB ________________

Relationship to patient ____

Employer ____

Employer Address ____

Dental History

Date of last dental examination __________ What was done at that time? ______________________

Former Dentist Name ______________________________ Phone ________________

Address ____

Are you having any pain or discomfort at this time? ❑ YES ❑ NO If yes, please describe: ________________

Medical History Information

Physician Name______________________________ Phone ________________

Address____

Are you now or have you been recently under treatment by a physician ❑ YES ❑ NO

If so, describe: ____

Date of last physical examination ____

Have you ever had any serious illnesses, operation or hospitalization? ❑ YES ❑ NO

If so, describe ____

Do you smoke or chew tobacco? ❑ YES ❑ NO

Do you consume alcohol? ❑ YES ❑ NO

Do you have or have you had any drug addictions? ❑ YES ❑ NO

Women Only: Are you pregnant or nursing? ❑ YES ❑ NO

Medical History Information (continued)

Do you have any allergies? (Medications, anesthetics, latex, metals, etc.) ❑ YES ❑ NO If YES, please list:

____

Do you have or have you had any of the following:

- ❑ Heart Failure
- ❑ Heart Disease
- ❑ Heart Attack
- ❑ Angina Pectoris
- ❑ Congenital Heart Disease
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Arteriosclerosis
- ❑ Mitral Valve Prolapse
- ❑ Artificial Heart Valve
- ❑ Heart Pacemaker
- ❑ Heart Surgery
- ❑ Stroke
- ❑ High Cholesterol
- ❑ Rheumatic Fever
- ❑ Hemophilia
- ❑ Anemia
- ❑ Blood Transfusion
- ❑ Glaucoma
- ❑ Kidney Disease
- ❑ Ulcers
- ❑ Acid Reflux/GERD
- ❑ GI Trouble or Disease
- ❑ Diabetes (Type I, Type II, or Gestations) HbA^1C%____
- ❑ Tumors
- ❑ Cancer
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ Thyroid Problems
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Liver Disease
- ❑ Sexually Transmitted Disease
- ❑ HIV or AIDS
- ❑ Cold Sores or Fever Blisters
- ❑ Lung Disease
- ❑ Emphysema
- ❑ Chronic Cough
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Hay Fever
- ❑ Sinus Trouble
- ❑ Artificial joints (hip, knee, etc.)
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Osteopenia or Osteoporosis
- ❑ Fainting or Dizziness
- ❑ Epilepsy or Seizures
- ❑ Mental Health Disorders (please explain)
- ❑ Special Needs or Disabilities
- ❑ Other conditions not listed:

____

Are you taking any anticoagulants, blood thinners or aspirin? ❑ YES ❑ NO If so, what is INR #_______

Please list all medications you are currently taking, including

prescription, herbal supplements, and over-the-counter: ____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature ____ Date ____________________________

Consent:

1. The undersigned hereby authorizes doctor to order 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.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with **(name of patient)** ___________________________. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 $^1/_2$ % finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau repots may be obtained.
5. I understand that is it my responsibility to advise your office of any changes in the information contained on this form.

Patient signature ____ Date __________ Witness ___________________________

____

Laurence H. Stone, D.D.S.

Office Use Only – Interim Update:

Patient Signature__________________________ Date________ Patient Signature__________________________ Date________
Patient Signature__________________________ Date________ Patient Signature__________________________ Date________
Patient Signature__________________________ Date________ Patient Signature__________________________ Date________
Patient Signature__________________________ Date________ Patient Signature__________________________ Date________