**Welcome**

LAKE PLACID™
FAMILY DENTAL
DAVID BALESTRINI, DMD

Today's Date ____________

## *Patient Information (confidential)*

_______Male _______Female

Patient Name______________________Birth Date____________Home Phone________________

Cell Phone______________________ Email______________________________

Employer________________City/State________________Work Phone______________Ext.______

Social Security #________________Driver's License #________________State of Licensure________

Mailing Address______________________City________________State____Zip__________

Physical Address(if different)________________City________________State____Zip__________

Check Appropriate Box: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

If College Student:College________________City/State________________Expected Grad. Date________

Emergency Contact Person________________Relationship__________Phone________________

Name of Person, office or other source referring you to our practice______________________

____Patient ____Doctor's Office ____Website ____Signage ____Yellow Pages ____Other ________________

## *Patient Preferences*

I would like Dr. Balestrini and his team to address me by:

____Mr. or Mrs. (last name) ____My first name Other:______________________________

I prefer to receive my appointment reminder call at __Home __Work __Cell Other: ______________ ____Any Listed

## *Dental Insurance Information* (subscriber is: person who holds the insurance)

Name of Subscriber______________________________Relationship to Patient________________

Subscriber's Birth Date________________Subscriber's ID#______________________________

Insurance Carrier Name________________Employer Sponsoring Insurance________________

Insurance Carrier Address______________________________________________

Insurance Carrier Phone______________________Group#______________________

## *Additional Dental Insurance (If Applicable)*

Name of Subscriber______________________________Relationship to Patient________________

Subscriber's Birth Date________________Subscriber's ID#______________________________

Insurance Carrier Name________________Employer Sponsoring Insurance________________

Insurance Carrier Address______________________________________________

Insurance Carrier Phone______________________Group#______________________

*I authorize release of any information concerning my healthcare, service and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor's office.*

Patient Signature X______________________________________ Date ________________

## *Patient Medical History*

Physician ______________________________ Office Phone ________________________ Date of Last Exam ___________

| Question | Yes | No |
|---|---|---|
| Are you under medical treatment now? | ☐ | ☐ |
| Have you been hospitalized for any surgical operation or serious illness within the last 5 years? | ☐ | ☐ |
| If yes, please explain ________________________________ | | |
| Are you taking any prescribed or OTC Medications, Vitamins or Herbal Supplements? Please list or attach. | ☐ | ☐ |
| Do you smoke or chew tobacco? | ☐ | ☐ |
| Do you drink alcoholic beverages? #_____/week | ☐ | ☐ |

| Are you allergic to or have you had any reactions to the following? | Yes | No |
|---|---|---|
| Local Anesthetics(e.g. novocaine) | ☐ | ☐ |
| Penicillin or other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates, Sedatives or Sleeping Pills | ☐ | ☐ |
| Codeine or other Narcotics | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any metals(e.g.nickel) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other(please list) _________________________ | ☐ | ☐ |
| **Women only**: Are you taking oral contraceptives? | ☐ | ☐ |
| Are you pregnant or think you may be? | ☐ | ☐ |
| Are you nursing? | ☐ | ☐ |

**Do you have or have you had any of the following?**

| Condition | Yes | No | Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | Heart Disease | ☐ | ☐ | Easily Winded | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Eating Disorder | ☐ | ☐ |
| Stroke | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Hay Fever/Allergies | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ | Angina/Chest Pains | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Fainting/Seizures | ☐ | ☐ | Blood Transfusion | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Asthma | ☐ | ☐ | Anemia | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Emphysema | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Epilepsy/Convulsions | ☐ | ☐ | Cancer | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Leukemia | ☐ | ☐ | Chemo or Radiation Therapy | ☐ | ☐ | Osteoporosis/Osteopenia | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Joint Replacement or Implant | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| Kidney Diseases | ☐ | ☐ | Hepatitis/Jaundice | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ | Arthritis | ☐ | ☐ | Fibromyalgia | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ | Stomach Troubles/Ulcers/GERD | ☐ | ☐ | Sinus Trouble | ☐ | ☐ |
| | | | Prolonged or Abnormal Bleeding | ☐ | ☐ | Other____________________ | ☐ | ☐ |

## *Patient Dental History*

Name of Previous Dentist and Location ________________________________________ Date of Last Exam ______________

| Question | Yes | No |
|---|---|---|
| Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| Are your teeth sensitive to hot/ cold liquids/foods? | ☐ | ☐ |
| Are your teeth sensitive to sweet/sour liquids/foods? | ☐ | ☐ |
| Are any of your teeth painful? | ☐ | ☐ |
| Do you have any sores/lumps in or near your mouth? | ☐ | ☐ |
| Have you had any head, neck or jaw injuries? | ☐ | ☐ |
| Do you have a dry mouth? | ☐ | ☐ |
| Have you had any jaw problems: | ☐ | ☐ |
| Clicking? | ☐ | ☐ |
| Pain(joint, ear, side of face)? | ☐ | ☐ |
| Difficulty in opening or closing? | ☐ | ☐ |
| Difficulty in chewing? | ☐ | ☐ |
| Do you have frequent headaches? | ☐ | ☐ |
| Do you clench or grind your teeth? | ☐ | ☐ |
| Do you have or wear a nightguard? | ☐ | ☐ |

| Question | Yes | No |
|---|---|---|
| Have you ever had any difficult extractions? | ☐ | ☐ |
| Prolonged bleeding after extractions? | ☐ | ☐ |
| Do you bite your lips or cheeks habitually? | ☐ | ☐ |
| Have you had orthodontic treatment? | ☐ | ☐ |
| Have you been diagnosed with gum disease? | ☐ | ☐ |
| Do you wear dentures or partials? | ☐ | ☐ |
| Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |
| Do you like the color of your teeth? | ☐ | ☐ |
| Do you like your smile? If no, what would you change?___________________________________ | ☐ | ☐ |

On a scale from 1-10(10 being the highest level), rate your level of anxiety at dental visits.______________________________________

## *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 understand that I am responsible for keeping Dr. Balestrini and team updated on changes in my health and medications at each dental visit. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me 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.

Signature of patient_____________________________________________________________________

Doctor's Comments___________________________________________________________________________

_____________________________________________________________________________________________

_______________________________Signature_____________________________________________________Date____________