

DR. CHERYL J. LAMPE, D.D.S., INC.  
Modern Dentistry in a Smalltown Atmosphere

# HEALTH HISTORY

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ Name you wish to be called \_\_\_\_\_  
Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

Best Time and Place to Reach You \_\_\_\_\_

Sex: M F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ (please circle) Single | Married | Widowed | Separated | Divorced

Patient SS # \_\_\_\_\_ Email Address \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ Employer Phone \_\_\_\_\_

Spouse Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

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IN CASE OF EMERGENCY, PLEASE CONTACT (someone not living with you)

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

Address and Phone Number of Emergency Contact Person \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to patient \_\_\_\_\_

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Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Is patient covered by additional insurance? Yes No Subscriber's name \_\_\_\_\_

Subscriber's Birthdate \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_  
and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all  
charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment  
of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature Relationship Date

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

*Please circle Yes or No to indicate if you have had any of the following:*

Bad Breath	Yes	No	Sensitivity to:		Grinding teeth	Yes	No	
Burning Sensation on tongue	Yes	No	* Hot	Yes	Orthodontic treatment	Yes	No	
Clicking or popping jaw	Yes	No	* Cold	Yes	Do you like your smile?	Yes	No	
Jaw pain	Yes	No	* Sweets	Yes	Had a serious or difficult problem with previous dental treatment?		Yes	No
Jaw tiredness	Yes	No	* Biting	Yes	How often do you brush?	_____		
Food collection between teeth	Yes	No	Dry mouth	Yes	How often do you floss?	_____		
Loose teeth or broken fillings	Yes	No	Mouth Breather	Yes	Types of bristles you use: <i>(please check)</i>			
Pain around ear	Yes	No	Cold sores/Blisters	Yes	Soft [ ] Medium [ ] Hard [ ]			
Bleeding/swollen gums	Yes	No	Smoking/Tobacco	Yes				
			Chew Tobacco	Yes				
			Nail biting	Yes				
			Lip/Cheek biting	Yes				

### ADDITIONAL NOTES

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## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Please circle Yes or No to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Fainting spells	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No	Psychiatric care	Yes	No
Artificial Heat Valves	Yes	No	Heart Problems:			Respiratory disease	Yes	No
Artificial Joints	Yes	No	* Rheumatic Fever	Yes	No	Scarlet Fever	Yes	No
Asthma	Yes	No	* Mistral Valve Prolapse	Yes	No	Shortness of breath	Yes	No
Back Problems	Yes	No	* Heart Murmur	Yes	No	Sinus trouble	Yes	No
Abnormal bleeding (with extractions or surgery)	Yes	No	Hepatitis	Yes	No	Skin Rash	Yes	No
Blood Disease	Yes	No	Type _____					
Cancer	Yes	No	Herpes/Venereal Disease	Yes	No	Special diet	Yes	No
Chemical dependency	Yes	No	High/Low Blood Pressure	Yes	No	Stroke	Yes	No
Circulatory problems	Yes	No	Meds _____			Swelling feet/ankles	Yes	No
Diabetes	Yes	No	Jaundice	Yes	No	Swollen neck glands	Yes	No
Wear Contacts?	Yes	No	Joint Replacement	Yes	No	Thyroid problems	Yes	No
Women:			Kidney Disease	Yes	No	Tonsillitis	Yes	No
Are you pregnant?	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Are you nursing?	Yes	No	Cough, persistent			Tumor or growth on head or neck	Yes	No
On birth control?	Yes	No	bloody?	Yes	No	Unexpected weight loss	Yes	No

Any hospital stays? (please explain)

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### MEDICATIONS

Please list medications you are currently taking:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pharmacy Name \_\_\_\_\_  
 Phone \_\_\_\_\_

### ALLERGIES (please check)

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	Other _____
<input type="checkbox"/> Latex	_____

I understand I am responsible for my account regardless of my insurance. I also understand that my insurance is an agreement between me and my insurance company.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

\_\_\_\_\_  
 Patient's Signature

\_\_\_\_\_  
 Date