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 _____

****

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** _____

****

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

367 S. Main St. Pataskala, Ohio 43062 • 740-927-4876 • www.CherylLampeDDS.com

Office Hours: Monday 9am - 6pm • Wednesday 9am - 5pm • Thursday 9am - 6pm • Friday 9am. - 1pm

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

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			**Hepatitis**	Yes	No	**Skin Rash**	Yes	No
extractions or surgery)	Yes	No	**Type** _____					
Blood Disease	Yes	No	**Herpes/Venereal Disease**	Yes	No	**Special diet**	Yes	No
Cancer	Yes	No	**High/Low Blood Pressure**	Yes	No	**Stroke**	Yes	No
Chemical dependency	Yes	No	**Meds** _____			**Swelling feet/ankles**	Yes	No
Circulatory problems	Yes	No	_____			**Swollen neck glands**	Yes	No
Diabetes	Yes	No	**Jaundice**	Yes	No	**Thyroid problems**	Yes	No
Wear Contacts?	Yes	No	**Joint Replacement**	Yes	No	**Tonsillitis**	Yes	No
Women:			**Kidney Disease**	Yes	No	**Tuberculosis**	Yes	No
Are you pregnant?	Yes	No	**Liver Disease**	Yes	No	**Tumor or growth on head**	Yes	No
Are you nursing?	Yes	No	**Cough, persistent**			**or neck**	Yes	No
On birth control?	Yes	No	**bloody?**	Yes	No	**Unexpected weight loss**	Yes	No

Any hospital stays? *(please explain)*

****

MEDICATIONS

Please list medications you are currently taking:

_____
_____
_____
_____

Pharmacy Name _____
Phone _____

ALLERGIES (*please check)*

__Aspirin
__ Barbiturates (sleeping pills)
__ Codeine
__ Iodine
__ Latex
__Local Anesthetic
__ Penicillin
__ Sulfa
Other _____
_____

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

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