JOSHUA LANE DENTAL
7255 Joshua Lane, suite B
Yucca Valley, Ca 92284 **760.365.8331**

Welcome to our office. Please print your answers to the following questions in order to assist us to help you. Your information is private and protected.

Name _____
Birth date _____ SS No _____
Mailing address _____
City_____ State _____ ZIP _____
Phone (home) _____ (Cell) _____
Email address _____
Employer _____ Phone _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT? (If self, skip to next section)

Name _____
Birth date _____ SS No _____
Mailing address _____
City_____ State _____ ZIP _____
Phone (home) _____ (Cell) _____
Email address _____
Employer _____ Phone _____

PRIMARY DENTAL INSURANCE

Insured Name _____ Ins. Name _____
Birth date _____ SS No _____ Ins. Address _____
Employer _____ City_____ State_____ ZIP _____
Emp. Address _____ Ins. Phone _____ Ext. ____
City _____ State _____ ZIP _____ Group No. _____ Plan _____

SECONDARY DENTAL INSURANCE

Insured Name _____ Ins. Name _____
Birth date _____ SS No _____ Ins. Address _____
Employer _____ City_____ State_____ ZIP _____
Emp. Address _____ Ins. Phone _____ Ext. _____
City _____ State _____ ZIP _____ Group No. _____ Plan _____

EMERGENCY CONTACT

Name _____
Relation _____ **Phone** _____
Physician _____ **Phone** _____

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Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
Do you take, or have you taken Phen-Fen or Redux? Yes No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

Women:

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local anesthetics Acrylic Metal Latex Sulfa drugs
Other If yes, please explain: _____

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

AIDS/HIV positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatment Yes No
Alzheimer's disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing problem Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed above? Yes No _____

Comments : _____
_____

Medications:

Please list any medications you are currently taking: _____
_____

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DENTAL INFORMATION

What is your main concern with your teeth? _____

(Please circle where applicable)

Bad breath or taste	Sensitive teeth	Clenching or grinding
Bleeding gums	Pain around ear	Frequent headaches
Difficulty chewing food	Dry mouth	Other

Long-term goals _____

Any trouble with previous dental treatment? _____

ORAL HYGIENE: what do you use?

Toothbrush	Floss	Interdental stimulators
Automatic toothbrush	Toothpicks	Water jet device
Fluoride supplements or gels	Other	

FEAR: please indicate (0=none, 1=mild, 2=moderate, 3=severe, 4=disabling panic)

Calling for an appointment	Sitting in dental chair	Having an injection
Waiting in the reception room	Having teeth x-rayed	Having teeth drilled
Smell of dental office	Seeing dental instruments	Having an extraction
Seeing the dentist	Having a cleaning	Losing control

Authorization

I authorize my dentist and his designated staff to perform an oral examination for the purpose of diagnosis and treatment planning including the taking of all xrays as a necessary part of this examination. If medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

FEES & PATMENTS

I understand an estimate of the charge for any procedure I may require will be given to me upon request. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that dental insurance is a method of reimbursement for fees paid to the doctor, and my insurance carrier may pay less than the actual bill for services.

SIGNATURE ON FILE

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor of the benefits otherwise payable to me.

Signature (parent or guardian, if minor) _____ Date _____

Witness name _____

Signature _____ Date _____