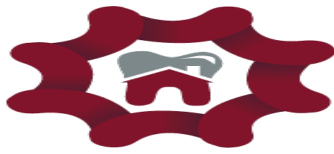

DENTISTRY OF MOUNTAIN VIEW

Alena Lynch, DMD
2708 NC-127 S
Hickory, NC 28602

Date________________Home Phone___________________________________Cell Phone____

Name____Sex ____M____F Age_______ DateOfBirth_______________
(Last) (First) (MI)

Address____City___________________________State___________Zip___________________
(Mailing Address)
Marital Status: Married______ Widowed______ Single______ Minor______ Separated______Divorced_____ Partnered_____

Patient Employer/School____Occupation____

Employer/School Address____ Work Phone_____________________________________

EMAIL ADDRESS:

____

Who is responsible for this account? _____________________________________Relationship to Patient? ___________________

Primary Insurance

Insurance Co. ____ Group#____

Subscriber's Name: ____ Birth Date: ______________________________________

SSN: ____ Employer: ____

If the patient has additional insurance please notify someone at the front desk
****WHEN FILING INSURANCE THE SOCIAL SECURITY NUMBER & DATE OF BIRTH OF THE POLICY HOLDER ARE REQUIRED****

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to Dentistry of Mountain View all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I certify that all of this information is true and accurate including the following medical information.

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 mark (X) to indicate if you have had any of the following

Bad Breath _____
Bleeding Gums____
Blisters on lips or mouth____
Burning sensation on tongue____
Cigarette, pipe, or cigar smoking____
Dry mouth____
Fingernail biting____
Food collection between teeth____
How often do you floss? _____________________

Grinding teeth_____
Gums swollen or tender____
Jaw pain or tenderness____
Lip or cheek_____
Loose teeth or broken filling____
Mouth breathing____
Mouth pain, brushing____
Orthodontic treatment____
How often do you brush? ________________________

Pain around ear_____
Periodontal treatment_____
Sensitivity to cold____
Sensitivity to sweets____
Sensitivity to heat____
Sensitivity when biting____
Sores or growths in mouth__

Health History

Physician's Name ____ Date of Last Visit
____

Name of Physician's Practice____Phone No_________________________________

Have you ever taken any of the group of drugs collectively referred to as "**fen-phen**"? These Include Combinations of Ionimin, Adipex, Fastin (brand names of phentermine, Pondimin (fenfluramine) and Redux (dexfenfluramme) ____Yes ____No
Have you ever taken any of the group of drugs collectively referred to as "**bisphosphanates**"? These include Fosamax, Zometa, Aredia, Actonel, and Skelid. ____Yes ____No
Do you have a history of bacterial endocarditis? ____Yes _____No *If yes when were you diagnosed? ________________

Are you on a Pain Contract?____Yes____No If so, with which Doctor? ____

Do you wear contact lenses? ___Yes ___No Do you use tobacco products? ___Yes ___No
WOMEN ONLY:
Are you pregnant? ___Yes ___NO Due Date _________/___________/_____________
MONTH/DAY/YEAR
Are you nursing? ___Yes ___No Taking Birth Control? ___Yes ___No

Place a mark (X) on "Yes" or "No" to indicate if you have or have any of the following:

AIDS/HIV ___Yes ___No
Anemia ___Yes ___No
Arthritis, Rheumatism ___Yes ___No
Artificial Heart Valve ___Yes ___No
Artificial Joints ___Yes ___No
Asthma ___Yes ___No
Bleeding abnormally, with Extractions or surgery ___Yes ___No
Blood Disease ___Yes ___No
Cancer ___Yes ___No
Chemical dependency ___Yes ___No
Chemotherapy ___Yes ___No
Circulatory Problems ___Yes ___No
Congenital Heath Lesions ___Yes ___No
Cortisone Treatments ___Yes ___No
Cough, persistent/bloody ___Yes ___No
Diabetes ___Yes ___No
Emphysema ___Yes ___No

Epilepsy ___Yes ___No
Fainting/Dizziness ___Yes ___No
Glaucoma ___Yes ___No
Headaches ___Yes ___No
Heart Murmur ___Yes ___No
Heart Problems ___Yes ___No
Hepatitis Type____ ___Yes ___No
Herpes ___Yes ___No
High blood pressure ___Yes ___No
Jaundice ___Yes ___No
Kidney Disease ___Yes ___No
Liver Disease ___Yes ___No
Low Blood Pressure ___Yes ___No
Mitral Valve Prolapse ___Yes ___No
Nervous Problems ___Yes ___No
Pacemaker ___Yes ___No
Psychiatric Care ___Yes ___No
Radiation Treatment ___Yes ___No

Rheumatic Fever ___Yes ___No
Scarlet Fever ___Yes ___No
Shortness or breath ___Yes ___No
Sinus trouble ___Yes ___No
Skin Rash ___Yes ___No
Special Diet ___Yes ___No
Stroke ___Yes ___No
Swollen Feet/Ankles ___Yes ___No
Swollen Neck Glands___Yes ___No
Thyroid Problems ___Yes ___No
Tuberculosis ___Yes ___No
Tumor or growth on head or Neck ___Yes ___No
Ulcer ___Yes ___No
Weight Loss ___Yes ___No
OTHER: ___________________________
____
____

Medications

Allergies

Please list any medications you are currently taking:

____

____

____
____

Please mark (X) on any of the following:

Aspirin ____ Local Anesthetic ____
Barbiturates ____ Penicillin ____
Codeine ____ Sulfa ____
Latex ____
Other (Please Specify):

Pharmacy Name ____ Phone: ____________________________________

Address____City________________________State________ZIP_____________________

Emergency Contact

Name ____ Relationship _____________________________________
LAST FIRST MI

Home Phone ____________________________ Cell Phone __________________________ Work Phone______________________