Welcome!

Shannon D. Lawson, D.D.S.
Family & Cosmetic Dentistry

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely.
The better we communicate, the better we can care for you.

ABOUT YOU

Today's date _____

Name _____
Last First MI

Birthdate _____/_____/_____ SS#_____

Home Address _____

City _____ State _____ Zip _____

_____ Single _____ Married _____ Divorced _____ Widow

Cell Phone ( ) _____

Work Phone ( ) _____

Email Address _____

Employer _____

Address _____

City _____ State _____ Zip _____

Occupation _____ How long?_____

How were you referred? _____

Previous/Present Dentist _____

Date of last visit _____/_____/_____

SPOUSE INFORMATION

Name_____
Last First MI

Birthdate _____/_____/_____ SS#_____

Employer _____

Work Phone ( ) _____

Who is responsible for this account? _____

_____

Relationship to patient _____

DENTAL INSURANCE INFORMATION

PRIMARY

Insurance Co. _____

Home Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Policy # _____

Group# _____

Insured's Name _____

Birthdate _____/_____/_____ SS#_____

Employer _____

Address _____

City _____ State _____ Zip _____

SECONDARY

Insurance Co. _____

Home Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Policy # _____

Group# _____

Insured's Name _____

Birthdate _____/_____/_____ SS#_____

Employer _____

Address _____

City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____

Relationship _____

Phone ( ) _____

MEDICAL HISTORY

Current physical health is ☐ Good ☐ Fair ☐ Poor

Are you currently under physician's care? ☐ Yes ☐ No

Explain _____

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Are you required to pre-medicate before dental appointments?

☐ Yes ☐ No If so, please list_____

Are you taking any prescription drugs? ☐ Yes ☐ No

Please list _____

_____

Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N Anemia/Radiation
Y N Artifical Bones/Joints
Y N Artificial Valves
Y N Arthritis/Asthma
Y N Blood Transfusion
Y N Cancer/Chemo
Y N Congnitl Heart Def
Y N Diabetes/TB
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema
Y N Epilepsy/Seizures
Y N Fainting Spells
Y N Heart Attack/Stroke
Y N Heart Murmer
Y N Heart Surgery/Pacemaker
Y N Hemophilia
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+AIDS
Y N Immuse Sys Disorder
Y N Kidney Problems
Y N Mitral Valave Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe Headaches
Y N Shingles
Y N Sinus Problems
Y N Ulcers/Colitis
Y N Venereal Disease

Please list any serious medical condiditons you have had _____

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Acetaminophen
Y N Codeine
Y N Latex
Y N Dental Anesthetics
Y N Ibuprofen
Y N Penicillin

Please list any other drugs you are allergic to _____

_____

Do you snore? ☐ Yes ☐ No

Do you have trouble sleeping? ☐ Yes ☐ No

Do you currently use a CPAP machine? ☐ Yes ☐ No

OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the patient herein.

Initials _____ **Date** _____

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

_____

_____

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, sweets or anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also authorize release of any information relating to this claim.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

X _____
Signature Date

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT

unless prior arrangements have been made.

Thank you for completing this form. It will enable us to help you more effectively. If you have any questions at any time, please ask.

We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.