TRACEY LYSANDER DDS
GENERAL AND COSMETIC DENTISTRY

GET ACQUAINTED QUESTIONAIRE

(Please fill forms out completely)

Purpose of this visit______________________ Date of last dental visit_____________ Today's Date______________

Are you currently experiencing any dental pain? Yes / No, If yes please describe________________________________

General Information (Patient):

Name____ Email ____

Home Phone____________________________________ Cell Phone ______________________________________

Address____

Street *City* *State* *Zip*

Occupation _____________________ Employer______________________ Work Phone_________________________

Date of Birth ______________________ Patient's Social Security Number ___________________________________

Patient's Spouse____________________________________ Spouses Employer_________________________________

Emergency Contact____ **Phone**_________________________________

Whom may we thank for referring you to our office? ____

Responsible Party Information:

Name of Subscriber: ____ Relationship to patient________________

Address (if different) ____Phone______________________________

Responsible party employer name and address____

Dental Insurance Company Name _____________________________________Group Policy No _________________

Insurance Co. Mailing address ____

Street City State Zip

Insurance Co. Phone___________________ **Insured S.S. #** ___________________ **Insured Date of Birth**____________

Please Note: In order to bill your insurance, we must of have both date of birth and social security number for the subscriber, in the alternative, you may pay at the time of visit, get and itemized bill and bill your own insurance.

Secondary insurance company________________________________ Insurance Co Phone ______________________

Insured Name____________________________ Relationship to Patient____________ Phone_______________________

Home address_______________________________________ S.S. # ______________________ Date of Birth __________

Employer Name & Address ____

Insurance Co. Mailing address ____

Street City State Zip

Please complete second form.

HEALTH HISTORY

Medical History Information

Name of physician________________________________City________________________Phone __________________________________

Date of last medical exam____________Are you currently under the care of a physician or other medical professional? Y/N

If yes, please explain____

Are you currently taking any medications? __________If yes, please list____

Are you allergic to any medications? __________________ If yes, please list ______________________________________

HAVE YOU EVR HAD ANY OF THE FOLLOWING (*please circle for yes)*

Hepatitis, Liver disease, Jaundice
Rheumatic fever
Diabetes
High blood pressure
Heart trouble (explain) _________________
Heart Murmur
Shortness of breath
Swelling of ankles or feet
Stroke (when) _______________
Blood trouble, Anemia, Leukemia
Serious Accident (Explain) ______________
Excessive bleeding requiring treatment
Venereal Disease
Lung problems (TB, Asthma, Emphysema)
Arthritis, Sore Joints
Fainting spells, Epilepsy, Convulsions
Headaches
Nervous Breakdown
X-ray, Indium or Cobalt treatment
Tumor or Cancer
Major Operation
HIV or AIDS
Have you ever taken the medication Phen Fen? Yes or No
Have you ever been treated for alcohol or substance abuse? Yes or No
Allergic reaction to Latex? Yes or No

Are You Now:

On a prescribed diet? Yes or No
Using Thyroid medication? Yes or No
Using hormones (including birth control pills)? Yes or No
(Woman) Pregnant? Yes or No

Have you ever been made sick by, allergic to, or told not to take any of the following: antibiotics, Novocain (or other dental anesthetic), Codeine, Aspirin, other drugs or medications, (please specify) _________________________

Do you smoke?________ If yes, how often _______________ Do you use smokeless tobacco? ________________If yes, how often________________
Do you use alcohol? _____________If yes, how often_________________

Please complete third form

Dental History

Are you dissatisfied with the appearance of your teeth? If yes, what concerns you the most?
____

1. Are there any growths, unhealed injuries, inflamed areas, or swellings in or around your mouth? ______
2. Do you have difficulty swallowing? ______
3. Do your gums bleed when brushing your teeth? ______
4. Have you ever been told that you have gingivitis or periodontal disease? _______
5. Have you ever been treated of gum (periodontal) disease? _______
6. Do you have any unpleasant odor or taste in your mouth? _______
7. Have you ever had professional instruction on dental home care? ______
8. Does food catch between your teeth? If yes, where? ________________________
9. Is any part of your mouth sensitive to temperature, pressure, or sweets? ___________
10. Have you ever had orthodontic treatment? _______
11. Have you ever treated for a 'bad bite'? ________
12. Does dental treatment make you nervous? ________
13. Do you have a clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely? ________________________________
14. Do you ever awaken with awareness of your teeth or jaws? _________
15. Do you clench or grind your teeth during the day or night? _________
16. Do you have any pain or soreness around your eyes, ears, other parts or your face, neck or shoulders? __________
17. Has your mouth ever locked open? _________

Consent for Treatment

I do authorize and give consent to administer treatment, including, but not limited to, local anesthesia, analgesia, and other such treatment which may be deemed necessary for the above named patient. I further state that the above medical and dental history was completed fully and accurately to the best of my knowledge.

Sign name ______________________________________ Date ________________

Financial Responsibility

I understand I am financially responsible, whether my insurance company pays or not, for all charges incurred by my dependents or me. I further agree that in the event of nonpayment, I will bear the cost of collection and/or court cost and reasonable legal fees should court action be required. I agree that a photocopy of this authorization shall be valid as the original.

Sign name ______________________________________ Date ________________

Authorization of Signature on File and Consent for Release of Information to Insurance Company

I hereby authorize Dr. Tracey Lysander DDS to bill my insurance company directly, to receive payment from the insurance company on my behalf, to furnish any information necessary to complete and/or settle my dental claim and I acknowledge that I have/will review the insurance claim form(s).

Sign name ______________________________________ Date________________

I acknowledge I have received a copy of this office's Notice of Privacy Practices

Patient/Guardian Signature ______________________________ Date ________________

Authorization for Release of Dental/Medical Records

Permission is herby granted to Dr. Lysander to request and review dental/medical records including dental charting, dental x-rays, periodontal charting and/or any other dental/medical record required for dental examination.

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Name of Patient or Guardian   Relationship to Patient

____

Signature of Patient or Guardian   Date

Attention Forwarding Dental Office: Please send most current bite wing x-rays, any FMX less than five years old, the most recent periodontal charting and any other pertinent information regarding this patient to traceydds2@yahoo.com
We can be reached at 858-674-6161 for other questions or concerns.

Thank you