Date_______________

Medical History and Consent

First Name_________________________ Last Name_______________________ Middle initial____ Preferred name______________
Sex ○ M ○ F Birth Day___________________ Age_______
Address____ City ________________________ State______ Zip__________
Home Phone _______________________ Cell/Mobile___________________________ Work_____________________ Ext________
Email ____ Preferred method of Contact ○ Call ○ Text ○ Email
Social Security Number___________________ Drivers License Number _______________________ state________
Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed Spouses Name ____________________________
Occupation ________________________ or if Student :○Part Time ○ Full Time Name of School ___________________________
Referred to us by __________________________________ Emergency Contact __________________________
Number____________ Relation to patient____________________
If Over 18 years old- I consent that LakeView Family Dental May talk to my parents regarding my treatment and account ○Yes ○ No
If Married- I consent that LakeView Family Dental may talk to my spouse regarding my treatment and account. ○Yes ○ No

Primary Insurance Information

PolicyHolder ________________________________
PolicyHolder Social Security Number__________________
Employer______________________________
Insurance Company __________________________
Relationship to PolicyHolder ○ Self ○ Spouse ○ Child ○ Other
PolicyHolder Birthday___________________
Employers Address____
Member ID ______________________ Group #__________________

Secondary Insurance Information

PolicyHolder________________________________
PolicyHolder Social Security Number__________________
Employer______________________________
Insurance Company __________________________
Relationship to PolicyHolder ○Self ○ Spouse ○ Child ○ Other
PolicyHolder Birthday___________________
Employers Address____
Member ID ______________________ Group #__________________

Medical Insurance Information

PolicyHolder________________________________
PolicyHolder Social Security Number__________________
Employer______________________________
Insurance Company __________________________
Relationship to PolicyHolder ○ Self ○ Spouse ○ Child ○ Other
PolicyHolder Birthday___________________
Employers Address____
Member ID ______________________ Group #__________________

List any medications you are taking:

Medication Dosage/Freq Prescriber Reason	Medication Dosage/Freq Prescribe Reason
1. ____	4.____
2. ____	5.____
3. ____	6.____

List and detail any medical conditions or history:
____
____
____

Primary Physician's Name: ____ Physicians phone # _______________________

Are you under the care of other physicians? If so, please list:

Physician Phone # Reason
____
____
____

Was your last dental experience pleasant? Y N What did you like best about your previous dentist? ___________
____

If you could change anything about your smile what would it be? ____
____

I agree that my physician(s) may be contacted to complete details of my medical history if required.
Please Initial___________

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.

Allergies

Acrylics Y N
Anaphalaxis Y N
Latex Y N
Local Anesthetics Y N
Penicillin Y N
Metal Y N
Sulfa Y N
Other Y N

List other known allergies:
____
____
____
____

Cardiovascular

Artificial Heart Valve Y N
Coronary Artery Disease Y N
Chest Pain or Angina Y N
Congestive Heart Failure Y N
Heart Attack Y N
Heart Murmur Y N
High Blood Pressure Y N
High Cholesterol Y N
Irregular Heart Beat Y N
Low Blood Pressure Y N
Mitral Valve Prolepse Y N
Pacemaker Y N
Tachycardia Y N

Endocrine

Diabetes Y N
Gout Y N
Hormonal Change Y N
Thyroid problems Y N

Eyes, Ears, Nose and Throat

Change in Hearing Y N
Change in Vision Y N
Dysphagia Y N
Ear Pain Y N
Glaucoma Y N
Hay Fever Y N
Nasal Obstruction Y N
Nose Bleeding Y N
Sinus Problems Y N
Tonsillectomy Y N
Tinnitus (Ringing) Y N

Gastrointestinal

Acid Reflux Y N
GERD Y N
Soft or Special Diet Y N
Ulcers Y N

General

Cancer Y N
Fatigue/Tired Y N
General Weakness Y N
Headaches Y N
HIV/AIDS Y N
Knee/Hip replacement Y N
Liver Problems Y N
Recent Trauma or Injury Y N
Rheumatic Fever Y N
Radiation Treatment Y N
Weight Change Y N

Hematological

Bleeding problems Y N
Hepatitis Y N

Oral

Bleeding gums Y N
Dry mouth Y N
Jaw problems (TMJ)? Y N
Clicking? Y N
Pain? Y N
Difficulty swallowing? Y N
Difficult Chewing? Y N
Orthodontics/Invisalign Y N
Periodontal Disease Y N
Teeth Clenching Y N
Tooth Pain Y N
Wisdom teeth extraction Y N
Removable teeth? Y N
Take any antibiotics for dental procedures? Y N

Musculoskeletal

Back Pain Y N
Fibromyalgia Y N
Joint Pain Y N

Neurological

Alzheimer's Disease Y N
Dizziness Y N
Fainting Y N
Memory Loss Y N
Multiple Sclerosis (MS) Y N
Muscle Weakness Y N
Seizures Y N
Stroke Y N
Tingling/Numbness Y N
Trigeminal Neuralgia Y N
Tremor Y N

Psychiatric

ADD/ADHD Y N
Anxiety Y N
Chemical Dependency Y N
Depression Y N
Eating Disorder Y N
Excessive Stress Y N
Memory problems Y N

Respiratory

Asthma Y N
Bronchitis Y N
Breathing problems Y N
Chest Pressure Y N
Congestion Y N
Dyspnea(shortness of breath) Y N
Emphysema Y N
Orthopnea Y N
Pneumonia Y N
Pulmonary Embolism Y N
Tuberculosis Y N

Sleep

Daytime Sleepiness Y N
Morning headaches Y N
Obstructive Sleep Apnea Y N
Do you use a CPAP? Y N
How Often?_____________________
Do you snore? Y N
Difficulty Sleeping/Insomnia? Y N

Social History

Do you smoke? Y N
__ Packs a day
Do you use smokeless tobacco? Y N
Do you drink alcoholic beverages? Y N
____ Drinks per day/week/month
History of substance abuse? Y N
Use of recreational drugs? Y N

Health History Update Has there been any changes in your health or medications since your last update?

Date __________________ N Y Comments ____ Signature____________________
Date __________________ N Y Comments ____ Signature____________________
Date __________________ N Y Comments ____ Signature____________________
Date __________________ N Y Comments ____ Signature____________________
Date __________________ N Y Comments ____ Signature____________________

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned herby authorize LakeView Family Dental to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize LakeView Family Dental to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that LakeView Family Dental choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by LakeView Family Dental. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of service provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for the services rendered not covered by my dental or medical insurance (if any). I Further consent to and agree to pay 1 ½ finance charge monthly (18%) annually that will be applied to any balance over 60 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Robert G. Nakisher, DDS, PLLC and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to him, and to handle any necessary claim appeal(s) on my behalf

CANCELLATION POLICY: a 48 hour notice must be given to cancel or change an appointment. We reserve the right to charge a $125 fee for broken appointments with less than 48 hour notice. After two broken appointments, we reserve the right to require a deposit in order to make another appointment. After a third broken appointment we reserve the right to dismiss you from the practice.

Consent (Adult)

Name of patient________________________________ ____ **Date**______________

Signature of Patient

Consent(for a minor child):

Name of Parent/ Guardian _____________________________ ___________________________________ **Date**______________

Signature of Parent/ Guardian

Authorization to Release Records

Certain Federal and State laws protect patients' rights to confidentiality of their health records. We cannot release a copy of any records without a signed and dated consent form from that patient/guardian. I hereby request and authorize you to release my dental records to / from **LakeView Family Dental** 7010 Pontiac Trail West Bloomfield MI, 48323

___________________________________ **Date** _____________________________

Signature of Patient

Notice of Privacy Practices

Patient privacy is important to our practice. We are required by law to maintain the privacy practices with respect to PHI (Protected Health Information). By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

___________________________________ **Date** _____________________________

Signature of Patient

Permission to use photographs, slides, and videos

I do hereby authorize **LakeView Family Dental** to use photographs, slides and/or videos of my face, jaw and the hard and soft tissues of my mouth. I understand that these photographs, slides and/or videos will be a part of my permanent dental records. I also understand that these photographs, slides and/or videos may be used for educational purposes, lectures, demonstrations, marketing and professional publications and I hereby authorize said use.

___________________________________ **Date** _____________________________

Signature of Patient