Dr. Natalie Nechvatal,
Light Touch Dental Care, Inc

7100 Spring Meadows West
Holland, OH 43528

CONFIDENTIAL PATIENT INFORMATION

PERSONAL INFORMATION

Name:	Birth Date:	Date:

How would you like us to address you? (nickname or short name?): _____

Address: _____ City: _____ State: _____ Zip: _____

Daytime contact numbers: (Please check the box of the preferred daytime contact number)

☐ Home: _____ ☐ Work: _____ ☐ Cell: _____

E-mail address: _____

Marital Status: ☐ Single ☐ Married

Social Security Number: _____

Please provide us the name of a person you would like us to contact in the event of an emergency:

Name: _____ Phone #: _____ Relationship: _____

Your occupation: _____ Employer: _____

How did you hear about our office? Is there someone we can thank for referring you to our practice?

_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:	Relationship To Patient:

Address: _____ City: _____ State: _____ Zip: _____

Daytime contact numbers: (Please check the box of the preferred daytime contact number)

☐ Home: _____ ☐ Work: _____ ☐ Cell: _____

Primary Insurance Information: (please show card)

Subscriber's Name: _____

Social Security Number: _____

Insurance Company: _____

Employer: _____

Subscriber ID: _____

Group Number: _____

Subscriber's Date of Birth: _____

Secondary Insurance Information: (please show card)

Subscriber's Name: _____

Social Security Number: _____

Insurance Company: _____

Employer: _____

Subscriber ID: _____

Group Number: _____

Subscriber's Date of Birth: _____

Insurance does not always cover all necessary dental treatments, exams or diagnostic services. It is also not always possible to predict if, or how much, a plan will pay for a particular service. Insurance companies do not guarantee payment, even when pre-treatment estimates are obtained. Patients utilizing insurance are ultimately responsible for payment of their bills. I understand that payment of my account is my obligation regardless of insurance, other third party involvement, or the presence or accuracy of pre-treatment insurance estimates.

Signature: _____ **Date:** _____

MEDICAL INFORMATION

Primary Physician's Name:	Physician's Phone #:	Date Of Last Exam:

Have you been seen by your physician for any ongoing conditions or been hospitalized over the past 5 years?

☐ **YES** ☐ **NO** If yes, please describe: _____

Please list any medications (prescription or over the counter) you are currently taking:

_____

Are you allergic to any medications/materials (Penicillin, aspirin, latex, codeine, sulfa, metals, etc)? ☐ **YES** ☐ **NO**

If yes, please list: _____

Check any of the following that you have had previously, or have at present:

☐ Heart Problems*	☐ Liver Disease	☐ Fainting	☐ Glaucoma
☐ High Blood Pressure	☐ Kidney Disease	☐ Asthma/Inhaler Use*	☐ Emphysema
☐ Heart Murmur (or MVP)*	☐ Thyroid Disease	☐ Tuberculosis (TB)	☐ Hepatitis B
☐ Bleeding/Bruising Easily	☐ Cancer/ Chemotherapy	☐ Chronic Sinus Issues	☐ Hepatitis C
☐ Anemia	☐ Radiation Therapy	☐ Joint Replacement*	☐ Diabetes
☐ Sexually Transmitted Disease	☐ Psychological Treatment*	☐ Alcoholism	
☐ HIV/AIDS/ARC	☐ Epilepsy/Seizure Disorder	☐ Drug Addiction	

***Please elaborate and also describe any conditions not listed above:** _____

_____

Do you use any tobacco products? ☐ **YES** ☐ **NO** If yes, what type(s) and how often do you use them?

_____

>> WOMEN: Are you presently pregnant, trying to become pregnant, or breast feeding? ☐ **YES** ☐ **NO**

DENTAL INFORMATION

When was the last time you were seen by a dentist? _____ Were dental radiographs taken? ☐ **YES** ☐ **NO**

How many times a day do you brush? _____ How many times a day do you floss? _____

Please list any other hygiene products you use regularly (e.g. Whitening toothpaste, mouthwash, tongue scraper, fluoride rinse):

_____

Have you ever been told that you have gum or periodontal problems? ☐ **YES** ☐ **NO** If yes, please describe:

_____

Do you have any sores or growths in and around your mouth? ☐ **YES** ☐ **NO** If yes, please describe:

_____

Do you clench your teeth? ☐ **YES** ☐ **NO** Do you grind your teeth? ☐ **YES** ☐ **NO**

Do you have pain in your jaw (TMJ) joints or have you been diagnosed with TMD? ☐ **YES** ☐ **NO**

Have you ever worn a nightguard or any other type of dental appliance? ☐ **YES** ☐ **NO**

Describe any difficulties you may experience when eating or chewing (e.g. food caught around or between teeth, pain, etc):

_____

Please list any problems or concerns you have in regard to your mouth or teeth (e.g. bad breath, tooth aches, etc):

_____

Do you feel nervous about having dental treatment? ☐ **YES** ☐ **NO**

Have you ever whitened your teeth? ☐ **YES** ☐ **NO** Are you interested in doing so? ☐ **YES** ☐ **NO**

I am: ☐ **Very Interested** ☐ **Somewhat Interested** ☐ **Not Really Interested** … in aesthetically improving my smile

CONSENT TO TREATMENT

I authorize treatment of the person named above by Light Touch Dental Care, Inc. I am responsible for informing the doctors about any changes in the above health history prior to treatment. I understand that this health history information is necessary for diagnosis and dental health care treatment by Light Touch Dental Care, Inc.

Signature: _____ **Date:** _____