DATE: _____

Creative Smile Designs
Family & Implant Dentistry

PATIENT INFORMATION:
Patient's Name
_____ Preferred or Nickname:_____
Street Address _____Home phone _____Cell Phone _____
City_____ST_____Zip _____Age_____Date of Birth_____Sex_____
Employer_____Work phone_____Contact Preference: Phone___Email___Text___
Social Security Number_____Single ____Married____Divorced____Widowed____Separated____
NAME OF PERSON RESPONSIBLE FOR ACCOUNT OR SPOUSE:
Name _____ Sex _____Social Security Number_____
Employed by_____Work Phone_____
Business Address_____Date of Birth_____
Position at Work_____Home phone_____ Cell phone_____
Your Email Address _____
Do you have insurance with your employer: Yes_____No_____
If yes, please provide the following information:
Dental Insurance Company #1_____ID Number _____Group Number_____
Address _____City_____State_____Zip_____
Insurance Company Phone_____Family members covered_____
Do you have any other dental insurance coverage:Yes_____No_____
If yes…This coverage is through: Spouse____Parent_____Other_____
Their name_____Sex_____Their Employer's Name _____
Their Social Security Number_____Their Birthdate _____
Dental Insurance Company #2_____Group Number_____
InsuranceCompany Address_____
City_____State_____Zip_____Insurance Company Phone Number_____

Please remember that insurance is considered a method of paying you for fees you pay to your Doctor and is not a substitute for payment of account. It is your responsibility to pay any amount not paid by insurance. The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, services rendered or to be rendered without obtaining my signature on each and every claim To be submitted for myself and /or dependents and that I will be bound by this signature as though the undersigned had personally signed that claim.

I give consent for release of any information (documents/x-rays) to health care providers or facilities relating to any referral or consult.

I/we give the above information for the purpose of obtaining credit and authorize you to obtain further information concerning any statement made from any source. I/we agree that all accounts will have up to 2% per month/24%APR service charge on all accounts last 30 days, and if more than one signature appears below, will be our joint in several obligations.

PATIENT/GUARDIAN Signature _____
Co-Applicant's Signature (Joint Account only)_____

Federal Equal Credit Opportunity Act prohibits Creditors from discrimination against credit applicants on the basis of race, color, religion, national origin, sex, marital status, age, or because you receive public assistance. The federal agency which administers compliance with this law concerning this office is the Federal Trade Commission.

## GETTING TO KNOW YOU

1. Why did you select our office?_____
   _____
2. Whom may we thank for referring you?_____
   _____
3. Is another member of your family or relative a patient in our practice? _____
4. Emergency contact: _____
   Phone:_____
5. When was your last dental visit? _____
   What was done at this appointment? _____
   _____
   When was the last time you had dental X-rays taken?___
   _____
6. Have you ever had teeth removed?_____
   How long have these teeth been missing?_____
   Have these teeth been replaced?_____
7. How do you feel about getting and maintaining a healthy mouth?_____
   _____
8. How do you feel about the appearance of your teeth?_____
   _____
9. If you could change anything about your smile, what would you change?_____
   _____

**A CHARGE WILL BE MADE FOR APPOINTMENTS BROKEN OR CANCELLED WITHOUT A 24 HOUR ADVANCE NOTICE.**

Patient Name: _____ Phone: _____ Date: _____

Email: _____ Address: _____ Emergency contact: _____

***MEDICAL HISTORY:*** Although dental personnel primarily treat the area around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you are taking can have an important impact with the dentistry you will receive. Please be sure to thoroughly and accurately fill out this health history:

**PLEASE ANSWER *YES* OR *NO* TO ALL QUESTIONS BELOW**
**IF YOU ANSWER YES TO ANY QUESTION BELOW. PLEASE CIRCLE WHICH PROBLEM(S) APPLY:**

| | YES | NO |
|---|---|---|
| **HEART PROBLEMS / DISEASE** | _____ | _____ |
| Heart Murmur / Irregular Heartbeat | | |
| Angina Pectoris / Mitral Valve Prolapse | | |
| Heart Surgery / Bypass Surgery | | |
| Artificial Heart Valve / Heart Pacemaker | | |
| Congenital Heart Lesions / Heart Attack / Disease | | |
| **LUNG / BREATHING PROBLEMS** | _____ | _____ |
| Emphysema / Asthma | | |
| Tuberculosis (TB) / Hay Fever | | |
| Breathing Problems / Frequent Cough | | |
| **KIDNEY PROBLEMS / DIALYSIS** | _____ | _____ |
| **HEPATITIS / YELLOW JAUNDICE** | _____ | _____ |
| Hepatitis A (Infectious) / Hepatitis Carrier | | |
| Hepatitis B (Serum) / Liver Disease | | |
| Hepatitis C (Non-A/Non-B) | | |
| **BLOOD PROBLEMS / DISEASE** | _____ | _____ |
| Anemia / Leukemia | | |
| Blood Transfusions / AIDS / AIDS Virus / HIV + | | |
| **ABNORMAL BLEEDING** | _____ | _____ |
| Blood Thinners / Hemophilia | | |
| **ALLERGIC** to any of the following: | _____ | _____ |
| _____ Acrylic _____ Metal _____ Latex | | |

| | YES | NO |
|---|---|---|
| **CANCER / TUMOR** | _____ | _____ |
| X-Ray/Radiation Treatment / Surgery | | |
| Tumors or Growths / Chemotherapy | | |
| **DIABETES** | _____ | _____ |
| Last A1C _____ | | |
| **ABNORMAL BLOOD PRESSURE** | _____ | _____ |
| **EPILEPSY / SEIZURES / CONVULSIONS** | _____ | _____ |
| **LIVER PROBLEMS / DISEASE** | _____ | _____ |
| **STROKE** | _____ | _____ |
| Cortisone / Steroids in last 2 years | _____ | _____ |
| Do you use recreational/nor-prescribed substances? | _____ | _____ |
| Ever had a serious head/neck injury? | _____ | _____ |
| Past or Present smoking / tobacco use? | _____ | _____ |
| How much? _____ How Long? _____ | | |
| **WOMEN:** | | |
| Are you pregnant or trying? | _____ | _____ |
| Taking contraceptives / birth control? | _____ | _____ |
| Are you nursing? | _____ | _____ |
| OSTEOPOROSIS? Have you ever taken Aredia, Nerexia, Zometa, Aclasta, Fosamax, Boniva, Actonel or any Medications with Bisphosphonates? | _____ | _____ |

**COVID? Y / N Date recovered? _____ Vaccine? Y / N**

**ALLERGIC** to Drugs / Medications. Yes _____ No _____ What? _____

**TAKING** Drugs / Medications. Yes _____ No _____ What? _____

**CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE OR HAVE HAD:** _____ ***NONE*** *of the following:*

| | | | | |
|---|---|---|---|---|
| Ulcers | Hives / Rash | Bruise Easily | Excessive Thirst | Stomach / Intestinal Problems |
| Herpes | Cold Sores /Fever Blisters | Pain in jaw Joints | Sinus Trouble | Venereal Disease (within last year) |
| Shingles | Fainting or Dizzy Spells | Drug Addiction | Frequent Headaches | **Artificial Joint** |
| Gout | Nervousness / Anxiety | Psychiatric Treatment | Numbness / Tingling | |
| Dry Mouth | Thyroid Disease | Parathyroid Disease | Sleep Apnea / C-PAP | |
| Chest Pain | Arthritis / Rheumatism | Alzheimer's / Dementia | Alcoholism | |
| Glaucoma | Thyroid Disease | Acid Reflux / GERD | Swelling of Limbs | |

DO YOU HAVE ANY OTHER CONDITION NOT LISTED? ***YES*** ***NO*** What? _____

HAVE YOU BEEN HOSPITALIZED IN LAST 5 YEARS _____ IF SO, FOR WHAT? _____

DATE OF LAST MEDICAL EXAM: _____ FOR WHAT? _____

Name of Medical Doctor _____ Pharmacy _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

_____ _____ _____

Signature of Patient / Guardian Date Doctor's Initials

# ACKNOWLEDGEMENT
# RECEIPT OF NOTICE OF PRIVACY PRACTICES
# FOR

**Edward J. Lynch D.D.S., P.C.**
**2006 Mt. Rushmore Rd**
**Rapid City, South Dakota 57701**

By signing below, I acknowledge that I have received the Notice of Privacy Practices from this practice.

I understand that the practice routinely confirms appointments and reminders about premedication and may leave messages on an answering machine, voice mail, e-mail, postcards, or with another family member.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Names of minor children

_____ _____

I give permission to share my Medical / Dental information with the following people :_____

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Patient Signature:_____