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 :_____

Patient Signature:_____