PLEASE COMPLETE THIS INFORMATION FOR OUR RECORDS

David Lester, D.D.S.

Patient Name:

_____

Last **First** **Middle**

Date of Birth: _____

Residence Address: _____

City: _____ **State:** _____ **Zip:** _____

Best Phone Number to Reach You: _____ **Alternate:** _____

Email: _____

How would you prefer that we contact you? VOICEMAIL EMAIL TEXT

IF APPLICABLE:

Dental Insurance Company: _____

Subscriber Name: _____ **D.O.B** _____

Subscriber Social Security Number: _____

Insurance ID Number: _____ **Group Number:** _____

Employer: _____

Business Address: _____

City: _____ **State:** _____ **Zip:** _____

Business Phone: _____

If you have additional insurance, please complete below:

Dental Insurance Company: _____

Subscriber Name: _____ *D.O.B.* _____

Subscriber Social Security Number: _____

*Insurance ID Number***:** _____ *Group Number:* _____

Employer: _____

How did you hear about us?

_____

Date of last Dental Visit: _____

Previous Dentist: _____

Have you had any trouble associated with previous dental treatment? _____

Emergency contact: _____

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MEDICAL INFORMATION

Physician's Name: _____

Physician's **Phone number:** _____

Are you in good health? _____

Date of last physical exam: _____

Have you been admitted to a hospital in the last three years? _____

If yes, for what reason? _____

Are you taking ANY medication? Yes: _____ **No:** _____

If yes, please list: _____

_____

Please circle any medications to which you are allergic:

PENICILLIN	**NOVOCAINE**	**ASPIRIN**	**CARBOCAINE**
CODEINE	**SULFA**	**XYLOCAINE**	**Other:** _____

Have you ever had any excessive bleeding that required special treatment? _____

Are you currently taking blood thinners?: Yes: _____ **No:** _____

Please circle ANY that you **may** *have OR* **have** *had:*

AIDS	**Drug Addiction**	**Asthma**	**Stroke**
Alcoholism	**Fainting Spells**	**Skin Problems**	**Liver Disease**
Anemia	**Rheumatic Fever**	**Muscle Problems**	**Allergies**
Epilepsy	**Kidney Trouble**	**Heart Troubles**	**Tumor**
Low Blood Pressure	**HIV Positive**	**Arthritis**	**Hypoglycemia**
High Blood	**Jaundice**	**Heart Murmur**	**Other:**
Pressure	**Sinus Problems**	**Tuberculosis**	_____
Diabetes	**Radiation Therapy**	**Hepatitis**	

Women: **Are you pregnant?:** _____ **How far along?:** _____

CONSENT FOR TREATMENT

I understand that it is the responsibility of the patient to inform Dr. Lester of any changes in their health. I, the undersigned (or legally responsible party), authorize and request the performance of dental services on myself (or the above named individual) and, further the performance of any operation rendered by the dentist and his staff. I also authorize the administration of such anesthetics or analgesics, local or inhalation which the doctor may deem advisable. Furthermore, I will be responsible for any financial obligations incurred for dental treatment upon myself (or the above name patient). I understand that the charges are my personal responsibility regardless of insurance benefits.

Signature: _____ **Date:** _____