New Patient Form | David Lester, DDS

Patient Name:

_____

Last **First** **Middle**

Date of Birth: _____

Address: _____

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

Best Phone Number to Reach You: _____

Email: _____

Emergency Contact (Name & Phone number): _____

How would you prefer we contact you to confirm about appointments?:

CALL TEXT EMAIL

IF APPLICABLE:

Dental Insurance Company: _____

Subscriber Name: _____ **Date of Birth:** _____

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: _____ **Date of Birth:** _____

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? Yes / No

If yes, please explain: _____

DISCLOSURE

David Lester, DDS has my authorization to disclose my Medical and Insurance information to the following person(s):

Name(s): _____

Phone: (_____) _____ **E-Mail:** _____

MEDICAL INFORMATION

Physician's Name: _____

Physician's Phone Number: _____

Have you been admitted to the hospital in the last three years? YES / NO

If so, for what reason? _____

Please list any medications you are currently taking: _____

_____

_____

Please circle any medications to which you are allergic:

PENICILLIN CODEINE ASPIRIN LIDOCAINE CARBOCAINE

OTHER: _____

Name and Location of Pharmacy for Prescriptions: _____

Have you ever had any excessive bleeding that needed special treatment? YES / NO

If yes, please explain: _____

Are you currently taking blood thinners: YES / NO

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

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

Are you pregnant? YES / NO

If yes, 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:** _____