



Juan R. Lopez, D.D.S.

DATE: _____

Dental Associates of Lawton
Gentle care that makes going to the dentist easy

6941 West Gore Blvd. (580) 536-9647 Lawton, Oklahoma, 73505

PATIENT NAME		Last	First	Middle	Nickname
ADDRESS: Street or P.O. Box # City State ZIP Code					PHONE NUMBERS: HOME: WORK: CELL:
AGE - Yrs.	BIRTH DATE	Mo.	Day	Year	BIRTHPLACE
				<input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Separated	
				SOCIAL SECURITY NO.	
OCCUPATION		EMPLOYER		HOW LONG EMPLOYED	DRIVERS LICENSE NO.
				ADDRESS & PHONE	
NAME OF SPOUSE / OR PARENT		ADDRESS		BIRTH DATE: Mo.	Day
				Year	RELATIONSHIP
				SOCIAL SECURITY NO.	
OCCUPATION		EMPLOYER		HOW LONG EMPLOYED	ADDRESS & PHONE

INSURANCE INFORMATION

INSURED PERSON'S FULL NAME		BIRTHDATE	
SOCIAL SECURITY	RELATIONSHIP TO PATIENT	WORK PHONE	
INSURANCE COMPANY NAME	GROUP OR UNION NAME	GROUP OR LOCAL NUMBER	
EMPLOYER NAME	FULL ADDRESS OF EMPLOYER		

GETTING TO KNOW YOU

- Why did you select our office? _____
- Whom may we thank for referring you? _____
- Is another member of your family or a relative a patient in our practice? _____
- Person to contact for emergency: _____
Phone: _____
- When was your last dental visit? _____
When was the last time you had complete dental x-rays taken? _____
- Have you ever had any teeth removed? _____
How long have these teeth been missing? _____
Have these teeth been replaced? _____
How Bridge Partial Denture

PAYMENT ALTERNATIVES

- Cash and personal checks are accepted as your treatments are provided.
- As a special service to you, we will give you a five percent (5%) courtesy discount if you pay for your treatment plan in full by cash or check.
- If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of you insurance payment; another service to you. This means that you are responsible for your deductible

- and the portion the insurance does not cover when you see the doctor. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and us.
- Mastercard, Visa, and Discover.
 - For those of you needing an extended payment program, our office offers Healthcare Credit Line or Dent-A-Med, which, when you are accepted, will allow extended small monthly payments for the treatment received. This is a health care credit card.

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I/We understand and agree that any credit granted shall be paid promptly in accordance with terms agreements, that the credit grantor may add one and one half percent (1 1/2%) per month to any balance owed, and in event of default to pay reasonable collection charges and/or attorney fees.

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

PLEASE COMPLETE FRONT AND BACK AND RETURN TO FRONT DESK

DENTAL HISTORY

1. What is the purpose of this visit? _____
2. Are you having any dental problems at this time? YES NO
3. Do your gums bleed at any time? YES NO
4. Do you feel very nervous about having dental treatment? YES NO
5. Have you ever had a bad experience in the dental office? YES NO
6. How do you feel about the appearance of your teeth? _____

7. If you could change anything about your smile, what would you change? _____

Doctor's Comments _____

MEDICAL HISTORY

8. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? YES NO
If yes, please list: _____
9. Have you ever had any excessive bleeding requiring special treatment? YES NO
10. Have you been a patient in the hospital during the past two years? YES NO
If yes, for what reason? _____
11. Have you been under the care of a medical doctor during the past two years? YES NO
If yes, for what reason? _____
12. Check any of the following which you have had or have at present:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> HIV Positive (AIDS) |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A (infections) |
| <input type="checkbox"/> Angina Pectoris (chest pain) | <input type="checkbox"/> Cough | <input type="checkbox"/> Hepatitis B (serum) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Asthma | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> X-Ray or Cobalt Treatment | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Bruise Easily |

13. Do you use tobacco in any form? YES NO
14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? YES NO
15. Do your ankles swell during the day? YES NO
16. Have you lost or gained more than 10 pounds in the last year? YES NO
17. Do you ever wake up from sleep short of breath? YES NO
18. Are you on a special diet? YES NO
19. Has your medical doctor ever said you have a cancer or tumor? YES NO
20. List all medications you are taking at this time _____

21. Women: Are you Pregnant? YES NO If yes, what month are you due? _____
Are you taking birth control pills? YES NO