Lillis Dental EXCELLENCE

Getting To Know You

NAME _____ DATE _____

What name would you like us to call you? _____

Please describe the reason for your consultation today: _____

_____

_____

How long has this been going on and what other events apply to today's visit? _____

_____

_____

Why have you decided to deal with this now? _____

_____

Have you consulted any other dentist about this? ____yes ____ no if yes, what was discussed or done?

_____

_____

When was your last dental check up? _____

Who is your regular or previous dentist? _____

Have you noticed or has any dentist or hygienist ever said that you:

Have gum disease (gingivitis)	____yes ____no	Lip or cheek biting	____yes ____no
Grind your teeth	____yes ____no	Loose or broken teeth or fillings	____yes ____no
Clicking or popping jaw	____yes ____no	Food collection between teeth	____yes ____no
Jaw pain or tiredness	____yes ____no	Sores, blisters or growths	____yes ____no
Pain around ear	____yes ____no	Bad breath	____yes ____no

Sensitivity to: ____cold ____heat ____sweets ____when biting or chewing

Would you like to know your options for: ____ Improve your smile ____Look younger ____Keep your teeth

What are your priorities and what would you like to see done now? _____

_____

_____

(913) 262-3368 • Fax (913) 648-6201
5600 West 95th Street, Suite 204 • Overland Park, KS 66207

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Personal Information - Health History

Date _____

NAME _____ Birthdate _____ Social Security No. _____

MAILING ADDRESS _____

MARITAL STATUS _____ SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED

HOW OR WHO REFERRED YOU TO OUR OFFICE? _____

PHONES: Work: _____ Home: _____ Fax: _____

Cell: _____ Pager: _____ Email: _____

OCCUPATION: _____ EMPLOYER & address _____

Spouse's OCCUPATION _____ EMPLOYER & address _____

ACCOUNT RESPONSIBILITY if someone other than yourself: NAME: _____

Their Social Security No. _____ Birthdate: _____

Mailing Address: _____ Daytime phone: _____

INSURANCE: If you have dental insurance, we will provide you with receipt documentation that can be attached to your insurance company form for proper filing. You will receive a reimbursement directly for whatever you are entitled to. The most important thing for you to know is the amount of your "calendar year maximum" which you can find by calling your insurance carrier.

HEALTH HISTORY (please check if you have or had any of the following)

___yes	___no	Are you in good health	___yes	___no	TB, Asthma or lung disease
___yes	___no	Has your health changed in the last year	___yes	___no	Hepatitis or liver disease
___yes	___no	Chest pain, shortness of breath	___yes	___no	Diabetes
___yes	___no	Bleeding problems, bruise easily	___yes	___no	Tumors, cancer
___yes	___no	Headaches, ringing in ears	___yes	___no	Radiation treatment
___yes	___no	Joint pain or stiffness, arthritis	___yes	___no	Psychiatric care
___yes	___no	Fainting or seizures	___yes	___no	Kidney or bladder disease
___yes	___no	Heart disease, murmurs, rheumatic fever, prosthetic heart valve	___yes	___no	VD, herpes
___yes	___no	Pacemaker	___yes	___no	HIV positive, AIDS, ARC
___yes	___no	High Blood pressure	___yes	___no	Pregnant: month _____
			___yes	___no	Birth Control Pills
			___yes	___no	Recreational drugs, smoking/alcohol

List any and all ALLERGIES: _____

List any and all DRUGS/MEDICATIONS you are taking: _____

List any and all SURGERIES: _____

___yes ___no Are you being treated by a Doctor now? If yes, who? _____

The above information is true and correct to the best of my knowledge:

PATIENT SIGNATURE: _____ DATE: _____

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