Welcome
to Layhill Dental

We are pleased to welcome you to our practice! Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information (Confidential)

Name _____ Age _____ Birthdate _____

Sex ☐M ☐F Cell # _____ Home # _____

Address _____ City _____

State ____ Zip _____ Email _____

☐Minor ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient's or Parent/Guardian's Employer _____ Work # _____

Spouse or Parent/Guardian's Name _____ Cell # _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Phone # _____

Pharmacy Name _____ Phone # _____

Responsible Party

Person Responsible for this Account _____ Birthdate _____

Relationship to Patient _____ Address _____

Home # _____ Cell # _____ Work # _____

Is this person currently a patient in our office? ☐Yes ☐No

Acknowledgement of Office Policies and Notice of Privacy Practice

Upon reading our Office Policies and Notice of Privacy Practice, please complete the following:

I _____ (Print Name of Patient or of Parent/Guardian)

have thoroughly read the Office Policies. I understand and agree to this and accept responsibility for my account. I acknowledge that I have received your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restriction, but if you do agree then you are bound to abide by such restrictions. I acknowledge I have been given the opportunity to ask any question I may have regarding the Notice of Privacy Practices.

_____ _____

Patient Signature (or Parent/Guardian) Date

Please complete both sides

Dental History

Former Dentist _____ Phone _____ Date of last exam _____

Check Y or N if you have had problems with any of the following:

☐Y ☐N Bad breath
☐Y ☐N Bleeding gums
☐Y ☐N Periodontal treatment
☐Y ☐N Sensitivity to sweet/sour
☐Y ☐N Sensitivity to hot/cold
☐Y ☐N Loose teeth
☐Y ☐N Sores/growths in mouth
☐Y ☐N Orthodontic treatment
☐Y ☐N Grinding or clenching teeth
☐Y ☐N Food collection b/w teeth
☐Y ☐N Broken fillings
☐Y ☐N Frequent headaches
☐Y ☐N Head, neck, or jaw injury
☐Y ☐N Prolonged bleeding after extractions

Have you ever experienced any of the following problems in your jaw?
☐Y ☐N Clicking/popping ☐Y ☐N Pain (joint, ear, side of face) ☐Y ☐N Difficulty in opening/closing

Medical History

Physician's name _____ Phone _____ Date of last visit _____

Have you had any serious illnesses or operations within the last 5 years? ☐Y ☐N
If yes, describe _____
Are you currently under medical care? ☐Y ☐N
If yes, describe _____
Have you ever taken Fen-Phen/Redux? ☐Y ☐N
Have you ever used a bisphosphonate medication (e.g. Fosamax, Actonel, Didronel, and Boniva)? ☐Y ☐N
Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours? ☐Y ☐N
Do you have a persistent cough or throat clearing not associates with a known illness (lasting more than 3 weeks)? ☐Y ☐N

Do you smoke or use other tobacco/ smokeless products? ☐Y ☐N
Circle all that apply: Cigarettes Cigars Vape Marijuana Chew Other _____
Are you wearing contact lenses? ☐Y ☐N
Are you allergic to the following? ☐Y ☐N
Local anesthetics (e.g. Novocain) ☐Y ☐N
Penicillin or any other antibiotics ☐Y ☐N
Sulfa drugs ☐Y ☐N Barbiturates ☐Y ☐N
Sedatives ☐Y ☐N Iodine ☐Y ☐N
Aspirin ☐Y ☐N Any Metals ☐Y ☐N
Latex rubber. ☐Y ☐N Other _____
Women: Are you pregnant? ☐Y ☐N
Nursing? ☐Y ☐N
Taking oral contraceptives? ☐Y ☐N

Do you have or have had any of the following:

	Y	N		Y	N		Y	N
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	STD/STI	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other _____		

Is patient currently taking any medications? If yes, list: _____

Authorization and Release

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize and request my insurance company to pay directly to the dentist otherwise payable to me for services rendered. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____