MICHAEL A. LOVDA, D.D.S., LTD.

CONFIDENTIAL REGISTRATION

DATE: _____

PLEASE PRINT

PATIENT NAME _____
FIRST MI LAST

BIRTH DATE _____

SS. # _____ D.L. # _____

ADDRESS _____
CITY STATE ZIP

YOUR EMAIL ADDRESS _____

SEX ☐ M ☐ F AGE _____

☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED

PATIENT EMPLOYER _____

EMPLOYER ADDRESS _____
CITY STATE ZIP

SPOUSE'S NAME _____

BIRTH DATE _____ SS.# _____

EMPLOYER: _____

EMPLOYER ADDRESS _____
CITY STATE ZIP

WHOM MAY WE THANK FOR REFERRING YOU? _____

PHONE NUMBERS

HOME (_____) _____ WORK (_____) _____ CELL PHONE (_____) _____

SPOUSE'S WORK (_____) _____ SPOUSE'S CELL PHONE _____

IN CASE OF EMERGENCY, CONTACT (SPECIFY SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD.)

NAME _____ RELATIONSHIP _____

HOME PHONE (_____) _____ WORK/CELL PHONE (_____) _____

DENTAL INSURANCE

SUBSCRIBERS NAME _____

BIRTHDATE _____ SS# _____

RELATIONSHIP TO PATIENT _____

INSURANCE CO. _____ PHONE: (_____) _____

GROUP # _____

ARE YOU COVERED BY ANOTHER PLAN? YES NO

IF YES PLEASE PROVIDE US WITH THE NECESSARY INFORMATION AND A COPY OF THE CARRIER'S INSURANCE ID CARD.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO MICHAEL A. LOVDA, D.D.S.

SIGNATURE: _____

DENTAL HISTORY

ARE YOUR TEETH SENSITIVE TO

HEAT	☐ YES	☐ NO
COLD	☐ YES	☐ NO
SWEETS	☐ YES	☐ NO
BITING PRESSURE	☐ YES	☐ NO
DOES FOOD CATCH BETWEEN YOUR TEETH	☐ YES	☐ NO
DO YOUR GUMS BLEED WHEN BRUSHING	☐ YES	☐ NO
HAVE YOU NOTICED ANY GUM SWELLING AROUND ANY TEETH	☐ YES	☐ NO
DO YOU HAVE UNPLEASANT TASTE OR ODOR IN YOUR MOUTH	☐ YES	☐ NO

PROBLEMS OF THE JAW

CLICKING OF THE JAW	☐ YES	☐ NO
PAIN (JOINTS, EAR, SIDE OF FACE)	☐ YES	☐ NO
DIFFICULTY OPENING OR CLOSING	☐ YES	☐ NO
DIFFICULTY CHEWING	☐ YES	☐ NO
DO YOU EVER AVOID ANY PART OF THE MOUTH WHILE BRUSHING	☐ YES	☐ NO
HAVE YOU HAD A REACTION TO A LOCAL ANESTHETIC	☐ YES	☐ NO
ARE YOU DISSATISFIED WITH YOUR TEETH & THEIR APPEARANCE	☐ YES	☐ NO

_____

ARE YOU CONCERNED ABOUT THE FINANCES REQUIRED TO RETURN YOUR TEETH TO EXCELLENT DENTAL HEALTH? ☐ YES ☐ NO

DO YOU GET FRUSTRATED BECAUSE YOU ALWAYS HAVE SOMETHING TO BE TREATED OR REPAIRED WHEN YOU VISIT A DENTIST? ☐ YES ☐ NO

DO YOU SMOKE OR CHEW TOBACCO? ☐ YES ☐ NO

HAVE YOU EVER HAD ANY TEETH REMOVED? ☐ YES ☐ NO

HOW LONG HAVE THESE TEETH MISSING? _____

DO YOU FEEL YOU WILL EVENTUALLY WEAR DENTURES? ☐ YES ☐ NO

DO YOU HAVE ANY FEARS? ☐ YES ☐ NO

WHEN WAS YOUR LAST DENTAL APPOINTMENT? _____

WHY DID YOU LEAVE YOUR LAST DENTIST? _____

_____

WHAT IS YOUR PRESENT PROBLEM? _____

_____

DO YOU WISH TO TALK TO THE DOCTOR PRIVATELY ABOUT ANYTHING? _____

_____

LOCAL ANESTHESIA: (Novocaine, Lidocaine, etc.) is given to block pain pathways in a localized area.

LOCAL ANESTHESIA WITH NITROUS OXIDE: Nitrous Oxide (or Laughing Gas) helps decrease uncomfortable sensations and offers some degree of relaxation.

The administration of any medication involves certain risks:

1. Nausea or vomiting.
2. An allergic or unexpected reaction.
3. Pain, swelling, inflammation or infection of the area at the injection site.
4. Injury to nerves or blood vessels in the area.
5. Disorientation, confusion, or prolonged drowsiness after dental work.
6. Cardiovascular or respiratory responses which may lead to other difficulties.

Fortunately, these complications and side effects are **not common.** Well-monitored anesthesia is generally very safe, comfortable, and well-tolerated. If you have any questions, PLEASE ASK.

FINANCIAL / POLICY

Every effort is being made to keep the billing and accounting costs of your dental care down. You will be asked to make payments at the time services are rendered. If you have dental insurance coverage, you are ultimately responsible for payment of your account. If you have dual insurance carriers this does not mean you will receive 100% coverage. You will be expected to pay your deductible and estimated portion at the time services are provided.

In accordance with the current health insurance portability and accountability act, we may, with your permission, disclose your health information to provide treatment, or to another doctor or health care provider providing treatment to you. We may also disclose your health information to obtain payment for services provided, to file your insurance claims via electronic submission and to provide appointment reminders, such as voice messages, postcards and letters. An unabridged copy of the health information privacy statement is available upon request.