7. ***PLEASE CIRCLE YES OR NO*** If you **are allergic to or have had a reaction to** any of the following.

Local anesthetics ……...**YES**	**NO**		Aspirin…….. **YES**	**NO**	
Penicillin……**YES**	**NO**		Codeine…..…..…… **YES**	**NO**	
Other antibiotics……**YES**	**NO**		Other narcotics……..**YES**	**NO**	
Sulfa drugs…….**YES**	**NO**		Latex gloves…….. **YES**	**NO**	
Barbiturates……**YES**	**NO**		Sedatives……**YES**	**NO**	

8. ***PLEASE CIRCLE YES OR NO*** If you **have or have had** any of the following diseases or conditions.

Asthma……...**YES**	**NO**		Tuberculosis……...**YES**	**NO**	
Diabetes……**YES**	**NO**		Epilepsy …….**YES**	**NO**	
Hepatitis……**YES**	**NO**		Jaundice/Liver Disease…. **YES**	**NO**	
Kidney disease…….. **YES**	**NO**		Abnormal-bleeding……**YES**	**NO**	
Cancer……... **YES**	**NO**		AIDS or HIV infection…..**YES**	**NO**	

9. Have you received any radiation treatments? **OR** in active chemotherapy? ….……..…**YES** **NO**

11. Are you currently being treated for osteoporosis or osteopenia? ……**YES** **NO**

IF YES, What form of treatment?_____

10. Do you take any kind of blood thinner, including aspirin?.....…….**YES** **NO**

12. Do you have any other allergy, condition or disease not listed that you think we should know about?……**YES** **NO**

IF YES, please explain_____

13. Have you had any serious trouble associated with any previous dental treatment?……..**YES** **NO**

IF YES, please explain_____

14. Non-Smoker _____ Smoker _____ Smokeless Tobacco _____ Vapor/E-Cigarettes _____

15. **WOMEN ONLY**: Are you ***or*** could you be pregnant?…….……..……**YES** **NO**

*****If you are a new patient, please answer the following:**

Referred by: _____ Former Dentist _____

How long since you saw a dentist? _____ Chief dental complaint _____

OUR OFFICE REQUIRES 24 HOUR NOTICE OF CANCELLATION OF APPOINTMENTS.

A CHARGE WILL BE APPLIED FOR MISSED APPOINTMENTS.

I certify that I have read and understand the above. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ **Date** _____

FOR PATIENTS WHO HAVE DENTAL INSURANCE / AUTHORIZATION AND ASSIGNMENT OF BENEFITS.

ALL NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. ***HOWEVER***, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE, IT IS CUSTOMARY TO PAY FOR SERVICES WHEN THEY ARE RENDERED.

I HEREBY AUTHORIZE **LAKEVIEW DENTAL, LTD**. TO FURNISH INFORMATION TO MY INSURANCE CARRIERS CONCERNING MY TREATMENT AND HEREBY ASSIGN TO **LAKEVIEW DENTAL, LTD**. ALL PAYMENTS FOR DENTAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY THE INSURANCE.

Signature _____ **Date**_____