PATIENT INFORMATION SHEET

1401 N.Kings Highway • Cherry Hill, NJ 08034
PH: **856.795.8080** • Dr. Howard Lassin, DMD, MAGD

Lassin Dentistry
COSMETIC • IMPLANTS • FAMILY & ADVANCED CARE

Patient name _____ Date _____

Address _____

Home phone _____ Work phone _____

EMail _____ Cell _____

Social Security No. _____ DOB _____

If patient is a minor, parent's or guardian's name _____

Whom referred you to our office? _____

Emergency, who should we call? _____ Relationship _____ Phone _____

RESPONSIBLE

Insured's name _____

Address _____

Social Security No. _____ DOB _____ Relationship to patient _____

Employer _____

Employer's address/phone _____

Insurance Company _____ Group No. _____

Address _____ Phone _____

Do you have dual coverage? yes no If yes, please complete the secondary insurance information.

Insured's name _____ Insured's Soc.Sec # _____

Insurance Company _____ Group No. _____

Address _____ Phone _____

DENTAL INFORMATION

1	Do your gums bleed when you brush?	yes	no
2	Are your teeth sensitive to hot or cold, pressure, sweets?	yes	no
3	Do you grind or clench your teeth?	yes	no
4	Do you have a fear of dental work?	yes	no

5 Date of last dental examination? _____ What was done at that time? _____

Name of previous dentist: _____

6 Describe your current dental needs or problems. _____

7 Are you interested in a brighter smile? yes no

MEDICAL HISTORY

1 Do you have to premedicate prior to your dental appointment? yes no

2 Have you been hospitalized during the past two years? yes no

3 Have you been under the care of a medical doctor during the past two years? yes no

Physician's name _____ Phone _____

If so, what reason/condition _____

5 Are you now taking any medication or drugs? yes no

If yes, please list: _____

6 Are you sensitive or allergic to any medication or anesthetics? yes no

7 Indicate which of the following you have had or have at present.

Heart Condition/Surgery	yes	no	Allergies or Hives	yes	no
Heart Murmur	yes	no	Hepatitis A (infectious)	yes	no
High Blood Pressure	yes	no	Hepatitis B (serum)	yes	no
Mitral Valve Prolapse	yes	no	Hepatitis C	yes	no
Artificial Heart Valve	yes	no	Venereal Disease	yes	no
Rheumatic Fever	yes	no	AIDS	yes	no
Arthritis	yes	no	HIV Positive	yes	no
Rheumatism	yes	no	Blood Transfusion	yes	no
Drug Addiction	yes	no	Hemophilia	yes	no
Stroke	yes	no	Anemia	yes	no
Artificial Joint(s)	yes	no	Liver Disease	yes	no
Kidney Trouble	yes	no	Epilepsy or Seizures	yes	no
Diabetes	yes	no	Fainting or Dizziness	yes	no
Cancer	yes	no	Nervousness	yes	no
Emphysema	yes	no	Tumors	yes	no
Tuberculosis	yes	no	Developmentally Disabled	yes	no
Asthma	yes	no	Allergy to Latex	yes	no

8 Do you have or have you had any disease, condition or problem not listed? yes no

If yes, please specify: _____

FOR WOMEN ONLY:

Are you pregnant? yes What month? _____ no

Are you nursing? yes no

Are you taking birth control pills? yes no

CONSENT:

1 The undersigned thereby authorize doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

2 I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____ . I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3 I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time of services are rendered unless other arrangements have been made. If payment(s) are not received upon in a timely fashion, I understand that a 1.1/2% finance charge (18%APR) may be added to my outstanding account. Also, I understand that where appropriate a credit report(s) may be obtained.

Patient _____ Date _____

Responsible Party _____ Relationship to Patient _____