Lifetime Dental

Scott Velgersdyk, D.D.S. • 2200 S. Minnesota Ave. • Sioux Falls, SD 57105 • 605-334-4121

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: ______________

E-Mail Address: ______________________________

Name: ______________________________
Last First Mi Mr Mrs Ms Dr

I prefer to be called: ______________ ☐ Male ☐ Female

Birthdate: __________ Age: ____ SS#: ______________

Home Address: ______________________________ Apt/Condo #

____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: ______________ Pager / Cell #: ______________

Wk #: ______________ Ext: ____ DL #: ______________

Employer: ______________________________

Employer's Address: ______________________________

____
City State Zip

How long there? ______ Occupation: ______________

Where & when are best times to reach you? ______________

Who may we thank for referring you? ______________

Other family members seen by us: ______________

☐ Previous ☐ Present Dentist: ______________

Last Visit Date: ______________

2 SPOUSE INFORMATION

His / Her Name: ______________________________

Employer: ______________________________

Wk #: ______________ Ext: ____ SS #: ______________

Birthdate: ______________ DL #: ______________

Person responsible for account: ______________

Wk #: ______________ Ext: ____ Hm #: ______________

Billing Address: ______________________________

Relationship: ______________ SS #: ______________

Employer: ______________ DL #: ______________

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ______________

Insured's Birthdate: ______________ Insured's ID #: ______________

Insured's Employer: ______________________________

Employer's Address: ______________________________

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ______________

Insured's Birthdate: ______________ Insured's ID #: ______________

Insured's Employer: ______________________________

Employer's Address: ______________________________

Neighbor or relative not living with you

His / Her Name: ______________ Relation: ______________

Wk #: ______________ Hm #: ______________

Address: ______________________________

____
City State Zip

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ______________________________

Phone #: ______________ Date of last visit: ______________

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ______________________________

CONTINUED ON BACK

4 MEDICAL HISTORY *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one:

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #:

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding	Y	N	Herpes / Fever Blisters
Y	N	Alcohol / Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+ / AIDS
Y	N	Arthritis	Y	N	Hospitalized for Any Reason
Y	N	Artificial Bones / Joints / Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer /Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Osteoporosis / Paget's Disease
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Treatment
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic / Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease / Traits
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any other drugs/materials that you are allergic to:

5 DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ **Yes** ☐ **No**

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? a day do you brush?

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it?

Are your teeth sensitive to heat, cold, or anything else?

Have you lost any teeth? ☐ Yes ☐ No If yes, why?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I have received a copy of this office's Notice of Privacy Practices.

Signature ______________________ Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature ______________________ Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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I verbally reviewed the medical / dental information above with the patient named herein. Initials: ______________ Date: ______________

Doctor's Comments: ______________________________

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MEDICAL HISTORY UPDATE

I have read my medical history dated _______ and confirmed that it states past and present medical conditions. ______________ Signature Date

I have read my medical history dated _______ and confirmed that it states past and present medical conditions. ______________ Signature Date

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