

# Welcome!

## Dr. Michael Casey + Dr. Mary Lenz

### Family Dentistry

To help us better serve you, please complete the following forms to the best of your ability.  
If you have questions, do not hesitate to let us know. Thank you for choosing our office!

Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Preferred Name/Nick Name: \_\_\_\_\_ DOB (MM/DD/YY): \_\_\_\_\_

Home Address: \_\_\_\_\_

☐ Single ☐ Married ☐ Widowed ☐ Divorced Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Children's Names: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

If not referred, how did you hear about us? \_\_\_\_\_

#### PARTNER INFORMATION

Partner Name: \_\_\_\_\_ Cell Number: \_\_\_\_\_ DOB (MM/DD/YY): \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

#### DENTAL INSURANCE:

Do you have dental insurance? ☐ Yes ☐ No

Insurance Company: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Subscriber's ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured's DOB (MM/DD/YY): \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_

#### SECONDARY DENTAL INSURANCE:

Do you have dual coverage? ☐ Yes ☐ No

Insurance Company: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Subscriber's ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured's DOB (MM/DD/YY): \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_

Patient Name \_\_\_\_\_

## MEDICAL HISTORY

Physician: \_\_\_\_\_ City: \_\_\_\_\_

Phone: \_\_\_\_\_ Date Last Seen/Reason: \_\_\_\_\_

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list: \_\_\_\_\_

Have you had any serious illness, operation, or hospitalization in the past? ☐ Yes ☐ No

Has there been a change in your health in the last two years? ☐ Yes ☐ No

Are you a "bleeder" or have you had excessive bleeding following dental treatment? ☐ Yes ☐ No

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

Do you smoke or use tobacco products? ☐ Yes ☐ No

How much? How long?: \_\_\_\_\_

Do you drink alcoholic beverages? ☐ Yes ☐ No

Have you had any of the following:

YES	NO	YES	NO	YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heart Murmurs		Thyroid Disorders		Stroke		Nervous Disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	High Blood Pressure		Bleeding Problems		Diabetes		Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Prolapsed Mitral Valve		Angina		Arthritis		Steroid Last 2 Years
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rheumatic Fever		Heart Attack		Headaches		Radiation/Chemo
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heart Problems		Pacemaker		Cancer		H.I.V. Positive
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Women Only:</b>	
	Kidney Disease		Emphysema		AIDS-Related Complex		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chemical Dependency Treatment		Asthma		Blood Disorders		Pregnant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hepatitis/Liver Disease		Dialysis		Joint Implants		Breast Feeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Oral Surgery Complications		Tuberculosis				

List ANY drugs or medicines that you are currently taking, including prescription drugs, non-prescription drugs, Aspirin, birth control pills and vitamins.

DRUG	DOSAGE/HOW OFTEN?	HOW LONG?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that the information I have given today is correct and to the best of my knowledge.

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_