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	
☐	☐	Heart Murmurs	☐	☐	Thyroid Disorders	☐	☐	Stroke	☐	☐	Nervous Disorders
☐	☐	High Blood Pressure	☐	☐	Bleeding Problems	☐	☐	Diabetes	☐	☐	Epilepsy/Seizures
☐	☐	Prolapsed Mitral Valve	☐	☐	Angina	☐	☐	Arthritis	☐	☐	Steroid Last 2 Years
☐	☐	Rheumatic Fever	☐	☐	Heart Attack	☐	☐	Headaches	☐	☐	Radiation/Chemo
☐	☐	Heart Problems	☐	☐	Pacemaker	☐	☐	Cancer	☐	☐	H.I.V. Positive
☐	☐	Kidney Disease	☐	☐	Emphysema	☐	☐	AIDS-Related Complex	Women Only:		
☐	☐	Chemical Dependency Treatment	☐	☐	Asthma	☐	☐	Blood Disorders	☐	☐	Pregnant
☐	☐	Hepatitis/Liver Disease	☐	☐	Dialysis	☐	☐	Joint Implants	☐	☐	Breast Feeding
☐	☐	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 _____