Steven E. Lynn, D.D.S.
2920 McIntire Drive, Suite 200
Bloomington, IN 47403

Patient Information:

Name_____ Age____ Birthdate_____ Sex_____

Address_____ City/State_____ Zip_____

Telephone( )_____ Cellular( )_____

Email Address: _____

SSN _____

Marital Status: Single Married Widowed Divorced Occupation_____

Employer _____ Employer Address_____ Phone_____

Whom may we contact in case of emergency?_____ Phone_____

How did you hear about our office?_____ Do you desire a

courtesy call prior to your appointments? Yes___ No___ If yes, at what number?_____

Best way to get in contact? Call ___ Text ___

Responsible Party Information:

Name_____ SSN_____ Birthdate_____

Relationship to Patient_____ Address_____

City/State_____ Zip_____ Employer Phone_____

Employers Name & Address_____

Dental Insurance Information:

Insurance Co._____ Member Name_____

Employer_____ Address_____

ID#_____ Group# _____ Insured Birthdate_____ SSN_____

Secondary Insurance Co_____ Employer_____

Name of Insured_____ SSN_____ Birthdate_____

ID#_____ Group#_____

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization including all fees incured in collecting the dental fees. I authorize release of dental/medical information for insurance purposes. I understand that if my insurance company has not paid within 60 days, the dental fees become my responsibility. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any of the above information. The parent who requests treatment and is present with a minor child at the time of treatment is responsible for all service rendered.

_____ Date _____

Signature of Patient or Parent if Minor

Medical History

Patient Name _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name_____ Address_____

Phone_____ Are you currently under the care of your physician? Yes____No____ List **ALL** medications you are currently taking, including over the counter_____

_____

Have you ever been hospitalized?Yes ___No____
Have you had a serious head or neck injury? Yes ____No____
Do you use tobacco? Yes ____No____
Do you use controlled substances? Yes ____No____
Are you on a special diet? Yes ____No____
Women: Are you ____Pregnant/Trying to get pregnant? ____Nursing ____Taking oral contraceptives?

Are you allergic to any of the following?
____Aspirin ____Penicillin ____ Codeine ____Acrylic ____Metal ____Latex ____Local Anesthetics
____ Tetracycline ____ Other_____

Do you have or have you had any of the following?

☐ Acid Reflux	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ AIDS/HIV Positive	☐ Cold Sores/ Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Alzheimer's disease	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anaphylaxis	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Anemia	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Angina	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal
☐ Arthritis/Gout	A1C____ Date ____	☐ Heart Pacemaker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Artificial Joint	☐ Easily Winded	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Asthma	☐ Emphysema	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Breathing Problem	☐ Excessive Thirst	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Cancer	☐ Frequent Cough	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice
☐ Chemotherapy	☐ Frequent Diarrhea			

Have you ever had any serious illness not listed above? ____Yes ____No

Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health/ It is my responsibility to inform the dental office of any changes in my medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN Date