Steven B. Lee, D.D.S., P.C.

Practice Limited to Periodontics

(260)471-1222 or (800)572-2655

Patient Name: _____
Last **First** **Middle** **Nickname**

Address: _____
(No P.O. Box Numbers) **Street** **Apt.#** **City** **State** **Zip**

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Social Security#:** _____

Phone #: _____ **Cell #:** _____ **Email:** _____

Emergency Contact:_____
Name **Phone #**

Emergency Contact Address: _____
Street **Apt. #** **City** **State** **Zip**

Whom may we thank for referring you? _____

Patient Representative: _____
Last **First** **Middle** **Nickname**

Address: _____
(No P.O. Box Numbers) **Street** **Apt.#** **City** **State** **Zip**

Relationship to Patient: _____ **Phone #:** _____

Social Security #: _____ **Date of Birth:**_____

Primary Dental Insurance: _____ **Subscriber Name:** _____

Relationship to Subscriber: _____ **Subscriber ID#:** _____

Subscriber Date Of Birth: _____ **Group Number:** _____

Employer Name/Address: _____

Secondary Dental Insurance: _____ **Subscriber Name:** _____

Relationship to Subscriber: _____ **Subscriber ID#:** _____

Subscriber Date Of Birth: _____ **Group Number:** _____

Employer Name/Address: _____

Our Office Policy is as follows: The patient representative who requests treatment for the child is responsible for all services rendered.

I hereby authorize Dr. Steven Lee to release to the insurance company information acquired in the course of dental care. Thereby authorize benefits to be paid directly to Dr. Steven Lee. I understand I am responsible for any unpaid balance.

Patient Representative Signature: _____

Method of Payment: ☐ **Cash** ☐ **Check** ☐ **Credit Card**

Health Information

Physician: _____ Pharmacy: _____

Date of last physical exam: _____ Results: _____

Yes	**No**	
___	___	Is child under care of physician now?
___	___	Is child receiving any medication or drugs? If yes, what: _____
		_____
___	___	Is there any excessive bleeding when cut?
___	___	Has child ever been hospitalized?
___	___	Has child ever had surgery?
___	___	Does child have good physical coordination?
___	___	Are there any emotional problems?
___	___	Allergies to medications? If yes, what? _____
		_____

History or Difficulty with any of the following:

Y	**N**	ADD/ ADHD	**Y**	**N**	Diabetes	**Y**	**N**	Mastoid
Y	**N**	Anemia	**Y**	**N**	Epilepsy	**Y**	**N**	Measles
Y	**N**	Aids or related complex	**Y**	**N**	Fainting	**Y**	**N**	Mononucleosis
Y	**N**	Asthma	**Y**	**N**	Hearing	**Y**	**N**	Mumps
Y	**N**	Bladder	**Y**	**N**	Heart	**Y**	**N**	Rheumatic Fever
Y	**N**	Cerebral Palsy	**Y**	**N**	HIV	**Y**	**N**	Thyroid
Y	**N**	Chicken Pox	**Y**	**N**	Kidney	**Y**	**N**	Tuberculosis
Y	**N**	Chronic Sinus	**Y**	**N**	Liver	**Y**	**N**	Venereal Disease
Y	**N**	Convulsions	**Y**	**N**	Malignancies	**Y**	**N**	Other _____

Please describe any current medical treatment, pending surgery, recent injuries, or any other information that we should be aware of.

_____

_____

_____

_____

I certify the above to be true and correct to the best of my knowledge.

Representative Signature: _____ **Date:** _____