Steven B. Lee, D.D.S., P.C.
Practice Limited to Periodontics

Patients Name: _____
Last First Middle Nickname

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

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

How long at this address? _____ **Home Phone #:** _____

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

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

Employer: _____ **Occupation:** _____ **How Long Employed:** _____

Employer Address: _____ **Phone #:** _____

Emergency Contact (Person not living with you): _____
Name Phone #

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

Whom may we thank for referring you? _____

Spouses Name: _____
Last First Middle Nickname

Spouses Employer: _____ **Occupation:** _____

Employer's Address: _____ **Phone #:** _____

Spouse's Social Security #: _____ **Spouse's 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: _____

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

Signature of Patient: _____ **Method of Payment:** ☐ **Cash** ☐ **Check** ☐ **Credit Card**

Medical History

Patient Name: _____ **Date:** _____

Physician Name: _____ **Phone #:** _____

Yes **No**

___ ___ Have you had any medical treatment or physician visit of any kind in the last two year? If yes, describe:

_____

_____

___ ___ Have you ever had any surgical operation of any kind? If yes, describe: _____

_____

_____

Have you been treated for or diagnosed with any of the following:

Yes	No		Yes	No	
___	___	Arthritis	___	___	Anorexia, Bulimia
___	___	Rheumatic Fever	___	___	Chemical Dependency
___	___	Heart Problems/Murmur	___	___	Psychiatric Treatment
___	___	Pre-med Recommended	___	___	Thyroid Condition
___	___	High Blood Pressure	___	___	Pacemaker; type _____
___	___	Low Blood Pressure	___	___	Joint Replacement
___	___	Anemia, Sickle Cell Disease	___	___	Pre-med Recommended
___	___	Epilepsy, Seizures	___	___	Allergies
___	___	Fainting Spells	___	___	Radiation or Chemotherapy
___	___	Diabetes	___	___	Ear Infections
___	___	Hepatitis; type _____	___	___	Chronic Sinus
___	___	Ulcers	___	___	Asthma
___	___	Kidney Disorder	___	___	Hemophilia, bleeding or blood disorder
___	___	Tuberculosis	___	___	Aids or Related Complex
___	___	Enzyme Deficiency	___	___	HIV
___	___	Mitral Valve Prolapse	___	___	Pregnant; delivery date _____
___	___	Smoke or Use Tobacco Products	___	___	Other _____
		Daily Intake _____			

___ ___ Have you ever had an allergic reaction or been told not to take any medications: If yes, describe: _____

_____

___ ___ Are you currently taking any prescription drugs of any kind? If yes, what? _____

_____

___ ___ Are you currently taking any non-prescription drugs of any kind (example: aspirin, cough syrup, herbs, nasal spray)? ___

_____

___ ___ Have you ever orally or intravenously taken a Bisphosphonate drug (example: Fosamax, Actonel, Boniva, Zometa)? ___

_____

___ ___ Have you been treated or being treated for cancer? Type? _____ When? _____

___ ___ Have you ever been treated for Osteoporosis, Osteopenia, or Post-Menopausal bone loss?

For office use only: Blood Pressure: S _____/D _____ Ht. _____ Wt. _____

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

Signature: _____ **Date:** _____