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

Practice Limited to Periodontics

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:** _____