Welcome

Bay Creek DENTAL CARE
The offices of Glenn G. Lew, DMD

We want to make your world a better place, with a healthy smile. Please complete this form so we can provide you with the comprehensive care you deserve. We thank you for choosing us to take care of you and your dental needs.

-Dr. Glenn Lew & Staff

1 About You

Today's Date: ___/___/___

Name: _____

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate ___/___/___ SS #: _____

Home Address _____

_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: _____ Cell / Other # _____

Wk #: _____ Ext: _____

E-mail: _____

How would you like to be contacted:

☐ E-mail ☐ Phone ☐ Text ☐ Postcard ☐ All

Employer:

Employer's Address: _____

How long there? _____ Occupation: _____

Best time and place to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

2 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Please give your insurance card to office staff to verify eligibility.

Insurance Co. Phone #: (___) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Please give your insurance card to office staff to verify eligibility.

Insurance Co. Phone #: (___) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

3 Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (___) _____ Cell #: (___) _____

SS #: _____

Birthdate: ___/___/___

EMERGENCY

In the event of an emergency, is there someone who lives near you that we should contact?

His/ Her Name: _____

Relation: _____

Wk #: (___) _____ **Ext:** _____

Hm #: (___) _____ **Cell #:** (___) _____

CONTINUED ON BACK

4 Medical History

Date of last health care exam: _____

What was this exam for? _____

Have you been hospitalized in the last 5 years? Yes No

If yes, reason: _____

Are you currently receiving medical care? Yes No

If yes, what for? _____

List physicians & phone numbers who are currently providing care for you:

_____

_____

For women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No

If no, are you planning a pregnancy in the near future? Yes No

Are you nursing? Yes No

Have you ever taken any biophosphonates (Fosamax®, Aredia®, Zometa®, Actonel®, or Boniva®)? Yes No

Have you ever had any of the following diseases or medical problems:

- Anemia or Blood Disorder
- Angina Pectoris
- Arthritis, Rheumatism, or any other inflammatory disease.
- Asthma
- Abnormal bleeding from a cut
- Cancer or tumor
- Colitis
- Diabetes Do you take insulin?
- Difficulty Breathing
- Emphysema or other respiratory/lung illnesses
- Epilepsy
- Fainting or Dizzy Spells
- Frequent Headaches Migraines
- Glaucoma
- Hay Fever
- Abnormal Heart or Previous Bacterial Endocarditis
- Heart Valve (artificial) or Heart Transplant
- Congenital Heart Disease
- Heart Disease or Heart Attack
- Heart Surgery
- Heart Stent When placed _____
- Hepatitis A B C
- Herpes / Fever blister
- High blood pressure Your normal BP _____/_____
- HIV / AIDS or ARC
- Hives
- Joint Replacement When placed _____
- Kidney Disease
- Liver Disease including jaundice
- Sore/Enlarged Lymph Nodes
- Pacemaker
- Psychosis
- Previous Biopsies
- Radiation or Chemotherapy Treatment
- Rheumatic / Scarlet Fever
- Seizures
- Shingles
- Sickle Cell Disease
- Slow Healing Mouth Sores
- Sinus Problems
- Snoring or Sleep Apnea
- Stroke
- Tuberculosis
- Ulcers
- Venereal Disease
- Other Conditions _____
- Recurrent Illnesses

Do you use tobacco? Smoke Chew None

How many times per day? _____

If you smoke, would you like to quit? Yes No

Do you consume alcohol? Yes No

Approximately how many alcoholic beverages per week?_____

Do you use any mood altering drugs? Yes No Type:_____

5 Medication History

List all the prescribed or over the counter medications that you take presently:

1. _____
2. _____
3. _____
4. _____

Are you taking any of these medications?

- Premedication before dental visit
- Antacids
- Dilantin or Tegretol ®
- Barbiturates (any)
- St. John's Wort or Kava-Kava
- Biaxin® (clarithromycin)
- Herbal medications Type: _____
- Tagamet ®(cimetidine)
- Prilosec ®(omelprazol)
- Cardizem® (diltiazem)
- Calan, Isoptin® (Verapamil)
- Diflucan® (fluconazole)
- Sporonox® (itraconazole)

Have you ever taken any prescription drugs such as fen-phen for weight loss? Yes Dates of use: _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? Yes No

Are you allergic or have you had a reaction to:

- Local anesthetics
- Penicillin or other antibiotic
- Apirin, Ibuprofen, or Tylenol
- Codiene, Valium, or other sedatives
- Latex
- Metals
- Others _____

6 Dental History

Why have you come to the dentist today? _____

Previous dentist name: _____ Date of last dental visit: __/____/____

Do you like the way your teeth look? Yes No

Describe the condition of your teeth and gums? Good Fair Poor

Are your teeth sensitive to? Hot Cold Pressure Sweets

Are you currently having pain or discomfort with your teeth or gums? Yes No

How often do you brush your teeth? _____ Floss your teeth? _____

Do your gums bleed when you brush? Yes No Floss? Yes No

Have you ever experienced pain in your jaw joint? Yes No

Have you ever been treated for TMJ symptoms? Yes No

Do you grind or clench your teeth? Yes No

Do you have any fear of dental treatment? Yes No

Would you like to try any of the following? Nitrous gas Conscious sedation

I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictist confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize Dr. Lew and his the dental staff to perform any neccessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission for the doctor or his staff to use any photos he may take to be used for lecturing, publishing, or education purposes.

Signature _____ ***Date*** _____