



Professional Lane Dental Associates

"Your pathway to dental health"

Dr. Tony W. Dollar Dr. Nancy M. Hein

Welcome to our practice! We are delighted that you have chosen our office to assist you in achieving your dental needs. Your dental health is very important to us. So we may provide you with exceptional dentistry, we need some important information about you.

Patient Information

Date of Visit: _____

Patient Name: Mr. _____ Mrs. _____ Ms. _____

Date of Birth: _____ SS# _____

Address: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____

Cell Phone: _____ Email: _____

As a courtesy to our patients, we confirm appointments 48 hours in advance. Please circle your preferred method of contact: **Home Work Cell Pager Email**

Whom may we thank for referring you to our office? _____

Account Information

Person responsible for this account: _____ Birthdate: _____

Address of responsible party: _____

Home Phone: _____ Work Phone: _____

SS#: _____ Employer: _____

WE ARE HAPPY TO FILE INSURANCE AS A COURTESY: will you need our assistance in filing your insurance? _____

Emergency Contact Information

Closest relative not living with you: _____

Address: _____ Phone: _____

DENTAL HISTORY

Reason for this visit _____

Date of last dental exam _____ Date of last Full Mouth X-Rays _____

Have you had any unfavorable dental experiences and/or do you have any dental fears?

If so, describe. _____

Do you have a family history of oral cancer? _____

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

	Yes	No		Yes	No
• Rheumatic fever, rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	• Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
• Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>	• Serious childhood disease	<input type="checkbox"/>	<input type="checkbox"/>
• Cardiovascular disease (heart problems)	<input type="checkbox"/>	<input type="checkbox"/>	• Are you allergic to or have you had any allergic reactions to:		
• Mitralvalve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Dental injection, local anesthetic (novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
• Is premedication required for Mitralvalve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other antibiotic. _____	<input type="checkbox"/>	<input type="checkbox"/>
• High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<small>Please List</small>		
• Anemia or blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>
• Asthma or Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Any other drug _____	<input type="checkbox"/>	<input type="checkbox"/>
• Diabetes (sugar in blood)	<input type="checkbox"/>	<input type="checkbox"/>	<small>Please List</small>		
• Kidney trouble	<input type="checkbox"/>	<input type="checkbox"/>	• Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
• Abnormal bleeding or delayed healing	<input type="checkbox"/>	<input type="checkbox"/>	• Are you currently taking any drugs or medication?	<input type="checkbox"/>	<input type="checkbox"/>
• Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what _____	<input type="checkbox"/>	<input type="checkbox"/>
• Shortness of breath, difficulty in breathing, emphysema, or any other lung disorder	<input type="checkbox"/>	<input type="checkbox"/>	• Do you have any condition that would be of value to know?	<input type="checkbox"/>	<input type="checkbox"/>
• Any artificial prosthesis (hip, knee replacement, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain. _____	<input type="checkbox"/>	<input type="checkbox"/>
• Is premedication required for artificial prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	• Are you now taking or have you had any x-ray therapy?	<input type="checkbox"/>	<input type="checkbox"/>
• Hepatitis, jaundice, or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain. _____		
• Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	• Do you consider yourself to have any possible exposure to Communicable Diseases?	<input type="checkbox"/>	<input type="checkbox"/>
• Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain. _____		
• Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>			
• Goiter or thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>			
• Convulsion or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>			
• Frequent nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>			

Name of family physician _____ Phone Number _____

AGREEMENT TO PAY: The undersigned accepts the fees charged as a lawful debt and promises to pay charges as outlined including the cost of collection, attorney fees, interest if applicable, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and the laws of the State of Alabama, or any other state.

Responsible Person: _____

I have received a copy of this office's Notice of Privacy Practices.

Patient Signature: _____