Lakeview Dental Associates
Phone: (203) 633-7178 | Fax: (203) 528-4965
1681 Meriden Road, Wolcott CT 06716

Name: ____________________________________ Preferred name to be called: ___________Birth Date: _____________ Sex: ____
First Middle Last

Social Security #: _________________ Marital Status: _____ Cell Phone #: ___________________ Alt. Phone #: _______________

Address: ______________________________________ ______________________ ___________ ___________
Number Street City State Zip

Primary Care Physician: ___________________________ Address/Phone # of PCP: __________________________________

E-Mail Address: _________________________________

How would you like to be confirmed for future appointments? (Circle One) Text, Email, or Phone Call

I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):
Name: ________________________________ Phone #: _____________________ Relationship: _____________________

Insurance Information (if applicable)

Primary Dental Insurance
Name of Insurance: _________________________________ Member ID#: ___________________________
Name of Primary Card Holder: ________________________ DOB of Primary Card Holder: _____________
Employer:____

Secondary Dental Insurance
Name of Insurance: _________________________________ Member ID#: ___________________________
Name of Primary Card Holder: ________________________ DOB of Primary Card Holder: ______________
Employer:____

*Please note that insurance is considered a method reimbursing the patient for fees paid to the doctor and not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or other balance not by your insurance.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including, private insurance, and other health plans to: Aurora Degollado DDS / Carlos Degollado DDS. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

____ ______________________
Signed Date

Patient's Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with the practice's Notice of Practices and that I have read and fully understood the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

Appointment Cancellation Policy: At Lakeview Dental, we are committed to delivering outstanding dental care to our patients. We recognize that unforeseen emergencies may arise; however, we kindly request a minimum of 24 hours' advance notice if you are unable to keep your appointment, allowing us to accommodate other patients in need of care. Failure to provide timely notice of cancellation will result in a missed appointment fee of $50, for which you will be directly responsible. This fee cannot be billed to insurance and must be settled in full prior to rescheduling. Your cooperation ensures efficient scheduling and optimal care for all our patients.

Patient Signature: _____________________________________ Date: __________________

Guardian Signature: ___________________________________ Date: __________________
(if patient is under the age 18)

Please complete the BACK page >>

DENTAL HEALTH INFORMATION- CONFIDENTIAL

Although dentists primarily treat the area around the mouth, it is important for us to know all facts relative to your present and past health. Certain medications and health conditions could have an important interrelationship with the treatment that you will be receiving. The following information is confidential.

Patient's Name ____ Age: ______________

Reason for today's visit? __________________________________ Date of last dental visit: _____________________________

Ever had Novocaine or another local anesthetic? ______________ If wearing dentures, age of dentures: _____________________

Are you taking aspirin or other **Anticoagulant (Blood Thinner)** therapy of any kind? _____________________________________

Are you taking or have taken any **Steroid/Cortisone** therapy in the last 2 years? ____

Are you taking **Biphosphonates** Therapy (Fosamax, Boniva, Actonel)? ____

Have you had an *adverse reaction* to **penicillin, aspirin, codeine, local anesthetics, latex, metals** or any other medication? ____

List any medications you are *Allergic* to:

1. ____ 3. ____
2. ____ 4. ____

List any medications you are taking including non-prescription drugs:

1. ____ 3. ____
2. ____ 4. ____

Check off if you have a history of any of these conditions:

- ☐ Rheumatic Fever
- ☐ Heart murmur
- ☐ Mitral Valve Prolapse
- ☐ Heart problem
- ☐ Pace maker/heart surgery
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart Valve Replacement
- ☐ Stroke
- ☐ Lung disease
- ☐ Breathing problems
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Allergies or Hives
- ☐ Diabetes
- ☐ Venereal Disease
- ☐ HIV positive/AIDS
- ☐ Blood transfusion
- ☐ Excessive bleeding
- ☐ Anemia
- ☐ Hepatitis (Type ___)
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Thyroid Disease
- ☐ Epilepsy or Seizures
- ☐ Fainting or dizzy spells
- ☐ Ulcers or stomach problems
- ☐ Arthritis
- ☐ Blood Disorders
- ☐ Sinus problems
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation treatment
- ☐ Use of tobacco products
- ☐ Drug addiction
- ☐ Alcoholism
- ☐ Psychiatric treatment
- ☐ Mouth sores/growths
- ☐ Teeth grinding/chewing
- ☐ Pain in your jaw
- ☐ Any type of implant
- ☐ Any type of transplant
- ☐ Artificial hip, knee or other joint
- ☐ Muscular Disorders

Other disease or illness: ____

Women: Is there a possibility of pregnancy? __________ If yes, estimated delivery date: _____/_____/______

Are you nursing? __________ Are you taking birth control pills? ____

Note: Antibiotics (such as Penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that my questions have been answered to my satisfaction.

____ ____

Patient/Guardian Signature Date Doctor's Signature Date

If Guardian Signature: Relationship to Patient _____________ Reviewed _______________ Initials ________

***Recall Review*:**

1) Patient's signature ____________________________ Dr's Signature______________________ Date: ____________
2) Patient's signature ____________________________ Dr's Signature______________________ Date: ____________
3) Patient's signature ____________________________ Dr's Signature______________________ Date: ____________