DENTAL IMPLANT GROUP

Chad S Lewison, DDS – Associate Fellow of the American Academy of Implant Dentistry
1110 West 5th Street • Canton, SD 57013
(605) 764-3179 • (866) 516-0570 – Toll Free
www.dentalimplantgroupsd.com

PATIENT INFORMATION:

Last Name: _____ First Name: _____Middle:_____

Preferred Name: _____ Date Of Birth: _____ Sex: ♂Male ♀ Female

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SS#: _____ Emergency Contact Name & Phone: _____

Medical Dr's Name :_____ Phone # of Medical Dr: _____

Name of Preferred Pharmacy: _____ Pharmacy Phone #: _____

How did you hear about our office?
☐ Dr Referral _____ ☐ Pt Referral _____
☐ Phone Book Ad ☐ Internet Search ☐ Website ☐ Other _____

DENTAL INSURANCE INFORMATION:

Primary Insurance Co: _____ Address: _____

City:_____ State: _____Zip: _____ Phone:_____

Policy Holder:_____ Relationship to Pt:_____

Date Of Birth: _____ Group/Policy #:_____ ID/SS #: _____

I authorize the release of a full report of examination findings, diagnosis, treatment planning, etc. , to any referring dentist or physician. I additionally authorize the release of any dental/medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature: _____ Date: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT HAVE CAUSED AN ALLERGIC REACTION:

□ **Antibiotics**
□ **Aspirin**
□ **Codeine**
□ **Latex**
□ **Local Anesthetics**
□ **Metals**
□ **Penicillin**
□ **Sedatives**
□ **Sleeping Aids**
□ **Sulfa Drugs**
□ **Other Allergies** _____

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD:

□ **Abnormal Bleeding / Bleed Easily**
□ **Anemia**
□ **Arthritis, Rheumatism**
□ **Asthma**
□ **Autoimmune Disorder (HIV or AIDS)**
□ **Bloating**
□ **Cancer**
□ **Chemotherapy**
□ **Chemical/ Substance Dependency**
□ **Chronic Dry Mouth**
□ **Chronic Bronchitis**
□ **Chronic Fatigue**
□ **Cold Hands/ Feet**
□ **Colitis**
□ **Current Pregnancy / Nursing**
□ **Depression/ Emotional Problems**
□ **Diabetes**
□ **Dizziness**
□ **Emphysema**
□ **Epilepsy/ Seizures**
□ **Excessive Thirst**
□ **Fainting Spells**
□ **Fluid Retention**
□ **Frequent Cough**
□ **Frequent Headaches**
□ **Frequent Illnesses**
□ **Frequent Urination**
□ **Gout**
□ **Hay Fever/ Sinus Problems**
□ **Heart Disease**
□ **Heart Attack, Heart Defects**
□ **Hearing Impairment**
□ **Heart Murmur**
□ **Heart Pacemaker**
□ **Heart Palpitations**
□ **Heart Valve Replacement**
□ **Heart Valve Damage**
□ **Hemophilia**
□ **Hepatitis:** □ **A** □ **B** □ **C**
□ **High Blood Pressure**
□ **Hypoglycemia**
□ **Hyperglycemia**
□ **Intestinal Disorders**
□ **Jaundice**
□ **Joint Pain/ Stiffness**
□ **Kidney Problems**
□ **Liver Disease**
□ **Lung Disease**
□ **Meniere's Disease**
□ **Muscle Aches, Spasms, Cramps**
□ **Muscular Dystrophy**
□ **Multiple Sclerosis**
□ **Neuralgia**
□ **Osteoporosis**
□ **Parkinson's Disease**
□ **Poor Circulation**
□ **Prior Orthodontic Treatment**
□ **Psychiatric Care**
□ **Radiation Treatment**
□ **Rheumatic Fever**
□ **Scarlet Fever**
□ **Shortness of Breath**
□ **Skin Disorder**
□ **Slow Healing Sores**
□ **Speech Difficulties**
□ **Stomach Ulcers**

□ **Tuberculosis**
□ **Urinary Disorder**

DO YOU HAVE OR HAVE HAD THE FOLLOWING:

□ **Blood Transfusions** _____ □ **Contact Lenses**
□ **Artificial Joints** _____ □ **Surgeries** _____

DO YOU TAKE OR HAVE YOU TAKEN:

□ **Alcohol** □ **Bisphosphonates: Fosamax, Boniva, etc.**
□ **Recreational Drugs** □ **Birth Control Pills**
□ **Tobacco in any form** □ **Pre-Med for Dental Procedures**

PLEASE LIST ANY PRESCRIBED MEDS & OVER THE COUNTER MEDS YOU ARE CURRENTLY TAKING:

_____ _____

_____ _____

_____ _____

PLEASE LIST ANY OTHER DISEASES OR MEDICAL PROBLEMS NOT LISTED ON THIS FORM.

_____

_____

Dental Implant Group

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

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

_____

Please Print Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, But acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communication barriers prohibited obtaining acknowledgement
___ an emergency situation prevented us from obtaining acknowledgement
___ Other (Please specify)

_____