LOMBARD Smiles

5610 N Lombard St.
Portland, OR 97203
(503) 283-2553

Date: _____

General Information:

Full Legal Name: _____ Preferred name: _____

Date of Birth: _____ Age: ___ Social Security Number: _____

Gender (Circle one): Male Female Non-binary Transgender

Preferred Pronouns (Circle one): He/Him She/hers They/them Other: _____

Phone Number: _____ Email: _____

Preferred Method of Communication (Circle one): Call Email Text

Address: _____ City: _____ Sate: _____Zip Code: _____

Preferred Language (circle one): English Spanish Russian Other_____

Do you need an Interpreter? (circle one) Yes No

If Child, Name of parent/guardian: _____

If you are completing this form for another person, what is your name and relationship to patient?

_____

What brings you in **today**? _____

Insurance Information:

Subscribers Name (i.e person on policy) _____

Subscribers Birthdate: _____

Name of Insurance Company _____

ID Number:_____ Group Number: _____

Insurance Phone Number: _____

Who's the carrier? (circle one): Self Spouse

Dental History (if Known):

Name of Previous Dentist and/or Office: _____

Date of Last visit:_____ Reason for visit: _____

Office Phone:_____ Address _____

Who may we thank for this referral? _____

Turn page for Medical history

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Medical History

Primary Care Provider name & Office: _____

City: _____ Phone Number: _____

Date of Last Physical examination: _____

Current list of all Medications taking including non prescriptions:

_____

_____

_____

For following question circle yes or no.

1. **Are you in good health?..... Yes No**
2. **Have there been any changes to your general health within the past year? ……..... Yes No**
3. **Are you now under the care of a physician?..... Yes No**
   If so, for what condition?_____
   _____
4. **Have you had any serious illness, operation, or have been hospitalized in the past 5 years?..... Yes No**
5. **Have you ever taken Aredia, Zometa, Fosamax, Actonel, or Boniva?..... Yes No**
6. **Do you have or have you had any of the following diseases or problems?**
   a. **Damaged or artificial heart valves, heart murmur or rheumatic heart disease …… Yes No**
   b. **Cardiovascular disease, angina, heart attack, and/or stroke …….. Yes No**
   c. **Osteoporosis …….. Yes No**
   d. **Cancer …… Yes No**
      If so, did you require IV Chemotherapy …. Yes No
   e. **Asthma or hay fever ……...Yes No**
   f. **Fainting spells or seizures …….. Yes No**
   g. **Diabetes ……... Yes No**
   h. **Hepatitis, jaundice, or liver disease…… Yes No**
   i. **AIDS or HIV Infection ……Yes No**
   j. **Thyroid Problems……. Yes No**
   k. **Respiratory problems, bronchitis.. etc…….Yes No**
   l. **Stomach Ulcer or Hyperacidity…… Yes No**
   m. **Kidney problems ……... Yes No**
   n. **High or Low Blood pressure ……. Yes No**
   o. **Sexually Transmitted Diseases …….. Yes No**
   p. **Epilepsy/other neurological disease ..…….. Yes No**
   q. **Problems with Spleen ……. Yes No**
   r. **Sleep Apnea ……. Yes No**
   s. **Emotional/Mental Health ……... Yes No**
   t. **Tobacco/Smoking …… Yes No**
   u. **Blood Transfusion ……Yes No**
   v. **Blood disorders/Anemia…….…… Yes No**
7. **Have you had abnormal bleeding?..... Yes No**
8. **Have you been treated for a tumor? ……Yes No**
9. **Are you allergic or have you ever had a reaction to:**
   a. **Local Anesthetics ……....Yes No**
   b. **Penicillin or Other Antibiotics …… Yes No**
   c. **Sulfa Drugs …… Yes No**
   d. **Barbiturates, sedatives, sleeping pills…Yes No**
   e. **Aspirin ……Yes No**
   f. **Iodine …… Yes No**
   g. **Codeine or other Narcotics …… Yes No**
   h. **Other _____**

Women:

10. **Are you pregnant? ……... Yes No**
    If so, Due date: _____
11. **Are you nursing…….. Yes No**

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Medical/Dental History Cont.

Do you require any special accommodations? ……...…… Yes No

If Yes, please explain: _____

Are there any other conditions wish to share? …… Yes No

If Yes, Please explain: _____

After initial x-rays and examination, you will be given an approximate estimate of fees for treatment. However, all estimates are based upon conditions presented at time of diagnosis; unforeseen circumstances could occur after an estimate fee. Also, additional charges will be made when pulp treatment (i.e root canal) is necessary.

I acknowledge that I'm financially responsible for all charges, if it becomes necessary to effect collections on any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including necessary attorney fees. I hereby authorize the doctor to release information necessary to secure payment, and have been informed there will be an 8% charge on any unpaid balance per month.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of their staff responsible for any errors or omissions that I may have made in completion of this form

_____ Date: _____
Signature of Patient (Or Parent/Guardian)

_____ Date: _____
Signature of individual filling out form, if not patient

_____ Date: _____
Provider Signature- E. Ramirez, DMD