Dear New Patient,

Welcome to our practice. We look forward to meeting you soon. Enclosed are our new patient forms. Please take a few minutes to fill them out, and bring them with you to your appointment. Although you may be able to fill in the forms on your computer, to insure patient privacy we ask that you please do not e-mail the completed forms to us.

Dr. Lizano is a Diplomate of the American Board of Oral Implantology / Implant Dentistry and his practice is limited to implant dentistry. He performs dental extractions, bone grafting and ridge augmentation, and dental implant treatment. Dental implants are an excellent way to replace missing teeth, and are an alternative to bridges and removable partial and full dentures, eliminating the problems we hear so many people with dentures and bridges describe. Implants can be used to replace a single missing tooth, a few missing teeth, or even an entire set of missing teeth.

At your initial appointment you will have a consultation with Dr. Lizano, and begin a diagnostic evaluation to determine the treatment possibilities for your case. Should you have any question about how this works, or the initial fees which you pay when you are here, please feel free to call me and I will be happy to discuss this with you.

It is our hope that you will find dental treatment in our office a pleasant experience.

Sincerely,

Dr. Anthony Lizano and Staff

MEDICAL

NAME OF PATIENT ______________________

TODAYS DATE __________ **AGE** ______

Select any conditions you have or have ever had:

- ☐ Asthma
- ☐ Palpitations
- ☐ Rheumatic Fever
- ☐ Anemia
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Severe Headaches
- ☐ Artificial Joint
- ☐ Artificial Heart Valve(s)
- ☐ Emphysema
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Ulcers
- ☐ Unusual Bleeding
- ☐ Hepatitis
- ☐ Cancer
- ☐ Convulsions
- ☐ Positive HIV Test
- ☐ Venereal Disease
- ☐ Blood Transfusion
- ☐ Endocarditis
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Heart Anomaly
- ☐ Fainting
- ☐ Osteoporosis
- ☐ Jaundice
- ☐ Chemotherapy
- ☐ Seizures
- ☐ Drug Reaction
- ☐ Organ Transplant
- ☐ Congenital Heart Condition

Have you been advised by your physician that you need to receive antibiotics before dental treatment? ◯ Yes ◯ No

Do you use Tobacco products? ◯ Yes ◯ No **How Often?** __________

Do you drink alcohol? ◯ Yes ◯ No **How Often?** __________

Do you use non-prescription drugs? ◯ Yes ◯ No

Women, are you pregnant? ◯ Yes ◯ No

Please list any prior surgery you may have had:

Please list any medications that you take:
(Include birth control pills, Pain relievers, Herbal or non-traditional remedies)

Please list any allergies or unusual reactions you may have had:

Have you received or are you receiving bisphosphonates?
Example: Zoledronic acid, Zometa, Pamidronate, Fosamax or Aredia

Is there anything else in your medical history that we have not covered?

Emergency Contact __________

Address __________

City ______ **State** ____ **Zipcode** ____

Phone Number __________

Who is your physician? __________

Address __________

City ______ **State** ____ **Zipcode** ____

Phone Number __________

SIGNATURE ______________________

DENTAL

NAME OF PATIENT ____________________ **TODAYS DATE** ____________________

Were you referred to this office? ◯ Yes ◯ No **By Whom?** ____________________

When did you last see a dentist? ____________ **Who?** ____________________

What was done? ____

What is the general condition of your teeth?

SELECT ANY CONDITIONS YOU HAVE

- ☐ Full Dentures
- ☐ Toothache
- ☐ Painful Gums
- ☐ Sore mouth
- ☐ Gagging
- ☐ Dental Implants
- ☐ Partial Dentures
- ☐ Sensitive Teeth
- ☐ Bleeding Gums
- ☐ Digestive Problems
- ☐ Jaw Joint Pain
- ☐ Oral Infection
- ☐ Bridges
- ☐ Difficulty Chewing
- ☐ Loose/Missing Teeth
- ☐ Unstable Teeth/Bite
- ☐ Facial Pain
- ☐ Periodontal Disease

Are you satisfied with your current dental restorations? If Not, why not?

Are you familiar with dental implants? ◯ Yes ◯ No

Do you have any pain, clicking, popping or grating sounds in your jaw joints? ◯ Yes ◯ No

Do you grind your teeth at night? ◯ Yes ◯ No

Have complications occurred after extractions? ◯ Yes ◯ No

What is the primary benefit you hope to obtain through your dental treatment?

FOR FULL AND PARTIAL DENTURE WEARERS:

Do you always wear your teeth? ◯ Yes ◯ No

Are your dentures comfortable? ◯ Yes ◯ No

Can you bite and chew effectively? ◯ Yes ◯ No

Do your teeth look good? ◯ Yes ◯ No

Do you bite you tongue cheeks or lips? ◯ Yes ◯ No

Do you have difficulty eating or speaking? ◯ Yes ◯ No

Do your teeth stay in place? ◯ Yes ◯ No

Do you get denture sores or pain? ◯ Yes ◯ No

Would you prefer secure teeth such as might be obtained with the help of dental implants? ◯ Yes ◯ No

Any health or financial problems that would prevent our considering the use of dental implants to help correct your dental problems? ◯ Yes ◯ No

SIGNATURE ____________________________________

NEW PATIENT INFORMATION

Last Name ______ **First Name** ______ **M.I.** ______

Home Address ______

City ______ **State** ______ **Zip Code** ______ **How Long?** ______

Home Phone ______ **Mobile Phone** ______ **Work Phone** ______

Email: ______ **Date of Birth** ______

Social Security # ______ **Sex** ◯ Male ◯ Female

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Other ______

Name of Spouse ______ **Spouse Date of Birth** ______

Spouse Social Security # ______ **Spouse Work Phone** ______

Your Employer ______ **Occupation** ______

Work Address ______ **How Long?** ______

Spouse Employer ______ **Occupation** ______

Work Address ______ **How Long?** ______

Patient Preferences:

- ☐ to learn every detail of my dental care
- ☐ The latest, technically advanced techniques
- ☐ Long-lasting solutions
- ☐ Least expensive option for care
- ☐ Just an overall explanation
- ☐ Only older, traditional methods
- ☐ Temporary, lower cost solutions
- ☐ Recommend optimal care

Do you have dental insurance? ◯ No ◯ Yes **Ins. Co.** ______

Address ______ **Phone** ______

Group # ______ **Plan Holder** ______ **Relation to Patient** ______

Are you covered by another plan? ◯ No ◯ Yes **Ins. Co.** ______

Address ______ **Phone** ______

Group # ______ **Plan Holder** ______ **Relation to Patient** ______

PLEASE NOTE THAT ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE. If you are covered by dental insurance, our office will be happy to bill your insurance company as a courtesy. Your insurance company will reimburse you directly.
I understand that responsibility for payment for services provided by this office is mine and if overdue, billing and finance charges will apply.

SIGNATURE ______ **DATE** ______

How will you be paying for your services? ◯ **Cash** ◯ **Check** ◯ **Credit Card**