Lilly Family Dentistry
2100 Indian Hills Dr.
Sioux City, IA 51104
Ph # : 712-239-5125
Fax # : 712-239-2275

Patient Personal Information

Title		Preferred Name		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				Emergency Contact	Emergency Phone #
Email				Student	SSN
Health Care Guardian Name				School Name	
Health Care Guardian Phone #				Referral Type	

Person responsible/guarantor for paying bills

Title		Preferred Name		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance? __ Yes __ No				**Do you have Secondary Dental Insurance?** __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergic To

- ☐ Y ☐ N Any Known Allergies?
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Clindamycin
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Any other Allergies
- ☐ Y ☐ N Other Narcotics

Check, if applicable

- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Bladder Trouble
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Disease
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bulimia
- ☐ Y ☐ N Breathing Problems
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Bruise Easily
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Color Blindness
- ☐ Y ☐ N Congenital Heart Defect
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hemophilia
- ☐ Y ☐ N Hepatitis A
- ☐ Y ☐ N Hepatitis B or C
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N High Cholesterol
- ☐ Y ☐ N Hives
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney Problems
- ☐ Y ☐ N Leukemia
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Scarlet Fever
- ☐ Y ☐ N Shingles
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sickle Cell Disease
- ☐ Y ☐ N Skin Rash
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Swelling of Limbs
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tonsillitis
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss
- ☐ Y ☐ N Yellow Jaundice

☐ Y ☐ N Any Known Concerns or Issues?
☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N Acid Reflux/Gerd
☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Anaphylaxis
☐ Y ☐ N Angina
☐ Y ☐ N Anemia
☐ Y ☐ N Aneurysm
☐ Y ☐ N Ankles Swell
☐ Y ☐ N Anorexia
☐ Y ☐ N Arteriosclerosis
☐ Y ☐ N Artificial Heart Valve
☐ Y ☐ N Arthritis
☐ Y ☐ N Asthma
☐ Y ☐ N Autism
☐ Y ☐ N Contact Lenses
☐ Y ☐ N Cortisone Medicine
☐ Y ☐ N Congestive Heart Failure
☐ Y ☐ N Damaged Heart Valve
☐ Y ☐ N Dementia/Alzheimer's Disease
☐ Y ☐ N Diabetes
☐ Y ☐ N Drug Addiction
☐ Y ☐ N Easily Winded
☐ Y ☐ N Embolism/Blood Clot
☐ Y ☐ N Emphysema
☐ Y ☐ N Environmental Allergies
☐ Y ☐ N Epilepsy/Seizures
☐ Y ☐ N Fainting Spells
☐ Y ☐ N Fever Blisters
☐ Y ☐ N Frequent Headaches
☐ Y ☐ N Frequently Dry Mouth / Sjogren
☐ Y ☐ N Gag Reflex
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lung Disease
☐ Y ☐ N Lupus
☐ Y ☐ N Mental Health Problems
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Osteoporosis
☐ Y ☐ N Pacemaker
☐ Y ☐ N Pain in Jaw Joints
☐ Y ☐ N Persistent Diarrhea
☐ Y ☐ N Pre-Med Needed
☐ Y ☐ N Prior Hepatitis
☐ Y ☐ N Radiation Treatment
☐ Y ☐ N Renal Dialysis
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Rheumatic Heart Disease
☐ Y ☐ N Urinate Frequently

Sleep Screening

☐ Y ☐ N Do You Snore
☐ Y ☐ N Current CPAP user
☐ Y ☐ N Stopped breathing while asleep
☐ Y ☐ N Unrefreshed sleep or fatigue
☐ Y ☐ N Are you CPAP intolerant
☐ Y ☐ N Have you had a sleep study

Other

☐ Y ☐ N See Scanned Documents: Pt Note
☐ Y ☐ N Blood thinner

Additional Comments

Dental Questionnaire

If you are an existing patient you can skip the Dental Questionaire and go to the next page

Dental Questionnaire

Name of previous Dentist _____

Phone _____

Date of your last cleaning _____

Last exam date _____

Date of your last full series x-rays _____

Date of last cavity detection (bitewing) x-rays _____

Do your gums bleed while brushing or flossing ? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? _____

Have you ever had burning of the tongue or cracking of the corners of your mouth ? _____

Do you chew/smoke tobacco in any form ? _____

Have you had any head, neck or jaw injuries ? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? _____

Do you clench or grind your teeth ? _____

Have you ever had orthodontic treatment ? _____

If Yes, date of placement _____

Do you wear dentures or partials ? _____

If Yes, date of placement of dentures ?

Are you happy with your dentures ?

Are you having any specific problems with your teeth, gums, or mouth at this time ?

Are you happy with your smile ?

Do you have problems with teeth/fillings breaking ?

Do you regularly use dental floss ?

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ?

Do you have difficulty in opening your mouth widely ?

Do you have an unpleasant taste or odor in your teeth/mouth ?

Does food catch between your teeth ?

Do you want to learn to control your dental disease and retain your teeth ?

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list

Medical Questionnaire

Emergency Contact *******Do not skip this section******

Emergency contact name

Emergency contact phone

Emergency contact relationship to patient

Medical Questionnaire

Family Physician

Phone

Are you currently under care of a Physician ?

If Yes, what is the condition being treated ?

Have you had any serious illness, operation or been hospitalized within the past 5 years ?

If Yes, what illness or problem ?

Are you currently taking any medication ?

If Yes, Please list medications you are taking

If you do not have a list of prescriptions with you today do you give us permission to look online?

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)

Have you ever taken the diet control drug Fen-Phen ?

Do you use alcoholic beverages ?

Do you smoke ?

Do you know your current A1 C number? If yes please list

If Yes please List current A1 C number

Any Disease, Condition or Problem not Listed ? Please list	
Are you taking any Denosumab Bone density injections ex.(Xgeva or Prolia)	
Are you on a Blood Thinner? ex. (Plavix, Eliquis, Lixiana, Xarelto, Coumadin)	
Have you had a heart attack?	
If yes please provide the date and the cardiologist's name	
Have you had a stroke?	
If yes please provide the date and the vascular neurologist's name	
Do you have an artificial heart valve?	
If yes we need you to provide dates and cardiologist's name	
Have you ever had mitral valve prolapse, prolapse repair or replacement?	
If yes please provide the dates and what the name of the surgeon was	
Do you have an artificial joint?	
If yes when was it placed, and the surgeon's name?	
Have you ever been told by a physician that you required pre-med antibiotic prior to dental work?	
If yes please list the reason for pre-medication and the physician that pre-scribed it.	

Women Only

Are you pregnant?	
If Yes, what is your due date ?	
Are you currently nursing ?	
Do you have menstrual period problems ?	
Are you on hormone replacement therapy ?	
Are you on birth control pills / fertility drugs ?	

Children Section Only

Is your child's water fluoridated?	
Does your child take fluoride supplements?	
Does your child suck their thumb/fingers?	
Does your child suck/bite their lip?	
Does your child bite/chew their nails?	
Does your child chew hard objects? (pencils, ice, etc)	
Does your child grind their teeth?	
Does your child clench their jaw?	
Does your child have any sensory sensitivities?	
If so, please explain:	
Is there anything we should be aware of prior to treating your child for Dental Treatment?	
Does your child snore?	

Is your child excessively tired during the day?	
Does your child wet the bed?	
Additional Comments	
Is there anything that is not listed above that you feel we should be informed about your health?	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**

Dentist Signature **Date**