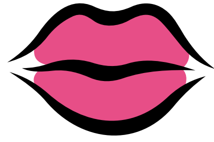

Miranda Lacy D.D.S., P.A.

3604 Preston Rd. Suite 400
Plano, Texas 75093
972-312-0000

Today's Date:__________________

Email Address:________________________

Name: ______________________________
LAST FIRST MI MR MRS MS DR

I prefer to be called: _______________

☐ Male ☐ Female DOB:__/__/____ Age: __

Home Address:________________________

____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Cell #:(___)__________Hm #:(___)_________

Wk #:(____)______________ Ext: ________

SS #:____________ DL #:_____________

Employer:____________________________

Occupation:___________ How long there?__

How did you hear about our office?

____

Other family members seen by us?

____

Medical Information

Physician's Name________________________

Phone #:(__)___________ Last visit:_______

Currently under the care of a physician? ☐ Yes ☐ No

Please Explain:_________________________

Pharmacy:______________ (__)_________

Dental Insurance

Insurance Co. Name, Address and Phone #:

____

____

____

Group, Plan, Local or Policy #:___________

Insured's Name:_________________________

Relationship to Patient:_________________

Insured's DOB:___/___/_____

Insured's ID#:__________________________

Insured's Employer and Address:

____

In the event of an emergency, who should we contact?

Name:______________________________

Relationship:__________________________

Cell/Home: (____)______________________

Work: (____)__________________________

Drug Allergies

_____ Aspirin _____ Acrylic
_____ Erythromycin _____ Latex
_____ Codeine _____ Penicillin
_____ Jewelry or Metals _____Sulfa Drugs
_____ Dental Anesthetic _____ Tetracycline

Other:_______________________________

Medical History

CHECK ALL THAT APPLY

_____ AIDS/HIV Positive
_____ Abnormal Bleeding / Hemophilia
_____ Acid Reflux / GERD
_____ Alzheimer's Disease
_____ Anaphylaxis
_____ Anemia
_____ Artificial Bones / Joints / Valves
_____ Arthritis, Rheumatism
_____ Asthma or Hay Fever
_____ Auto-Immune Disease
_____ Back Problems
_____ Blood Transfusion
_____ Cancer: Type/Dates________________
_____ Chemotherapy: Dates________________
_____ Radiation: Areas/Dates_______________
_____ Chronic Cough
_____ Chemical dependency
_____ Cold sores/Fever blisters/Mouth ulcers
_____ Chest pain, angina
_____ Congenital heart defect
_____ Crohns Disease
_____ Diabetes: Date Diagnosed: __________
Type________
_____ Difficulty Breathing
_____ Drug / Alcohol Abuse
_____ Dry Eyes / Dry Mouth
_____ Eating Disorders
_____ Emphysema / Glaucoma
_____ Epilepsy / Seizures / Fainting Spells
_____ Excessive Thirst
_____ Heart Attack Year: _________
_____ Heart Murmur
_____ Heart Surgery / Pacemaker

Please list all prescription, over-the-counter medications or supplements you take:

____

____

____

_____ Hepatitis, Liver Disease
_____ High / Low Blood Pressure
_____ Hospitalized for Any Reason
Specify:_________________________
_____ Hypoglycemia
_____ Immune Suppressed
_____ Irregular Heartbeat
_____ Kidney Disease
_____ Mitral Valve Prolapse
_____ Psychological Problems
_____ Pregnant:_____ weeks / Nursing
_____ Rheumatic fever / Scarlet fever
_____ Severe / Frequent Headaches
_____ Shingles
_____ Sickle Cell Disease / Traits
_____ Seasonal Allergies / Sinus Problems
_____ Stroke Year: _________
_____ Stomach Ulcers / Colitis
_____ Surgery in the last 12 months
_____ Swollen Ankles, Feet, Hands
_____ Taken Fosamax/bisphosphonate/PhenFen
_____ Thyroid: Hypo / Hyper
_____ Tobacco use: Past / Present
_____ Tuberculosis (TB)
_____ Venereal Disease

Please list any other serious medical condition(s) that you have ever had:

____

____

____

____

The information I have given is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services I may need during diagnosis and treatment with my informed consent.

____

Signature Date