Thomas J. Drockton, D.D.S. Michael C. Rodriguez, D.D.S.

Landerbrook Dental Professionals
5825 Landerbrook Drive, Suite 222
Mayfield Heights, OH 44124
216-752-8888

GENERAL INFORMATION

☐Dr.
☐Mr.
☐Mrs.
☐Miss, Ms. _____ Birth Date _____
Last First Middle

How would you like to be addressed in our office? (Title and/or Name) _____

Residence Address _____ (____)_____
Number Street City State Zip Code Telephone

Cell Phone (_____)_____ Work Phone (_____)_____Ext._____

E-Mail Address _____

Marital Status _____ Social Security Number _____

Occupation _____ Employer _____

Address of Employer _____ (____)_____
Number Street City State Zip Code Telephone

In case of an emergency, please contact _____

Relationship to Patient _____ Telephone Number (_____)_____

If patient is a minor, who is legally responsible? _____

Address _____ (____)_____
Number Street City State Zip Code Telephone

By whom were you referred? _____

DENTAL INSURANCE INFORMATION

Name of Dental Insurance Plan _____ Group Number _____

Employee _____ Employee's Social Security No. _____

Employee's Birth Date _____ Relationship to Employee _____

MEDICAL HISTORY

Family Physician _____ Specialty _____

Address _____ (____)_____
Number Street City State Zip Code Telephone

Additional Physician _____ Specialty _____

Address _____ (____)_____
Number Street City State Zip Code Telephone

Height _____ Weight _____ Age _____ Date of last complete medical examination _____

PLEASE TURN THE PAGE

Do you have or have you had any of the following? Please indicate with a Y (Yes) or N (No).

____ Any heart problems
____ High blood pressure
____ Low blood pressure
____ Circulatory problems
____ Heart murmur
____ Artificial valve
____ Mitral valve prolapse
____ Excessive bleeding

____ Allergies to anesthetics
____ Allergies to medicines or drugs
____ Allergy to latex
____ Allergies to _____

____ Acid Reflux
____ Anemia
____ Arthritis
____ Asthma
____ Cancer
____ Diabetes
____ Emphysema
____ Epilepsy
____ Hepatitis
____ HIV (Aids Virus)
____ Joint Replacement

____ Malignancies
____ Measles
____ Mumps
____ Nervous Problems
____ Osteoporosis
____ Prosthetic (Pins or Plates)
____ Psychiatric Care
____ Radiation Treatments
____ Rheumatic Fever

____ Scarlet Fever
____ Sleep Apnea
____ Sinus Problems
____ Thyroid Problems
____ Typhoid Fever
____ Tonsillitis
____ Tuberculosis
____ Ulcer
____ Venereal Disease

Blood Pressure: S_____/D_____/P_____ Date _____

Please encircle (YES) or (NO.) If YES, please fill in the details.

Yes No Do you have a current medical problem? What? _____
Yes No Have you had pains in the chest or shortness of breath? _____
Yes No Do your ankles swell? _____
Yes No Do you take tranquilizers or sedatives? How often? _____
Yes No Do you take aspirin? How often? _____
Yes No Have you been advised not to take any medication? What? _____
Yes No Have you had any major operations? What kind? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Are you taking any medication? Please list:

Taking _____ For _____ Taking _____ For _____
Taking _____ For _____ Taking _____ For _____
Taking _____ For _____ Taking _____ For _____

Yes No Do you take more than one alcoholic drink per day? How many? _____
Yes No Do you use tobacco? How much? _____
Yes No Is your diet medically supervised? For what purpose? _____
Yes No Are you pregnant? Expected delivery date _____

Medical History Updated (For Office Use)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

DENTAL HISTORY

Previous Dentist _____ **Period of treatment** _____ **Specialty** _____

Address _____ (____)_____
Number Street City State Zip Code Telephone

Other Dentist _____ **Period of treatment** _____ **Specialty** _____

Address _____ (____)_____
Number Street City State Zip Code Telephone

Last dental visit _____ **Last full mouth X-ray** _____ **Last complete dental exam** _____

What is your immediate dental concern? _____

Please encircle (YES) or (NO.) If YES, please fill in the details.

Yes No Are you presently in any dental pain? _____

Yes No Have you experienced any unfavorable reaction to dentistry? _____
What? _____

Yes No Have you lost any teeth? From what cause? _____

Yes No Have you ever had orthodontic treatment? When? _____

Yes No Do you have any growths or swellings in your mouth? How long have they existed? _____

Yes No Do you have any difficulty in swallowing? _____

Yes No Do your gums bleed when brushing your mouth? _____

Yes No Do you avoid brushing any part of your mouth? Why? _____

Yes No Have you ever been told you have pyorrhea? When? _____

Yes No Is any part of your mouth sensitive to temperature, pressure or food or drink? What? _____

Yes No Do you have a burning sensation of your mouth? _____

Yes No Have you ever had a bad reaction to a dental anesthetic? When? _____

Yes No Does food catch between your teeth? _____

Yes No Do you have any pain or soreness around your eyes or ears or other parts of your face?
When? _____

Yes No Are you aware of stiff neck muscles? How often? _____

Yes No Do you ever awaken with an awareness of your teeth or jaws? How often?_____

Yes No Are you aware of clenching your teeth during your daytime hours? How often? _____

Yes No Have you ever been told you grind your teeth during sleep? How often? _____

Yes No Have you ever been told that you snore while sleeping? How often?_____

Yes No Are you aware of your jaw clicking or popping while eating or yawning? How often? _____

Yes No Do you have difficulty in opening your mouth widely? _____

Yes No Do you have “tension” headaches? How often? _____

Yes No Do you have an unpleasant taste or odor in your mouth?_____

Yes No Are you dissatisfied with your teeth and their appearance? _____

Yes No Do any members of your family, including your parents, wear dentures? _____

Yes No Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?

PLEASE TURN THE PAGE

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____

Drs. Drockton/Rodriguez appreciate the confidence you have shown in choosing us to provide for your dental care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees.

As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. You will be responsible for your balance in full.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. I understand that I will be responsible for any charges incurred by NOT providing the most current, correct insurance information to Drs. Drockton/Rodriguez. In the event of default, I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection, as well as pay any fees associated with returned checks.

I have read the above policy regarding my financial responsibility to Drs. Drockton/Rodriguez, for providing dental services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Drs. Drockton/Rodriguez.

Patient /
Legal Guardian Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Drs. Drockton/Rodriguez to release dental information acquired in the course of my examination or treatment, to my insurance company, or other dentists and/or physicians required to participate in my care.

Patient /
Legal Guardian Signature _____ Date _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY POLICY

I acknowledge that I have received a copy of Drs. Drockton/Rodriguez Privacy Policy.

Patient /
Legal Guardian Signature _____ Date _____

CANCELLATION / NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call, if possible, 48 hours prior to your appointment.

I understand that I may be charged a service charge for a no show. I also understand that a no show for three appointments or cancellations of a total of four consecutive appointments, may result in a discharge from further dental care.

Patient /
Legal Guardian Signature _____ Date _____