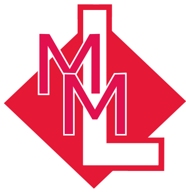

Marius M. Laniauskas, D.D.S.
Landerbrook Dental Professionals
5825 Landerbrook Drive, Suite 222
Mayfield Heights, OH 44124
216-752-8888

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 ____________________

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
____ 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

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

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 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 you feel you will eventually wear full artificial dentures? _____________________________

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?

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: ____

Drs. Miller/Laniauskas 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. Miller/Laniauskas. 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. Miller/Laniauskas, 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. Miller/Laniauskas.

Patient /
Legal Guardian Signature ___________________________________ **Date** ____________________

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Drs. Miller/Laniauskas to release dental information acquired in the course of my examination or treatment, to my insurance company, or other 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. Miller/Laniauskas 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** ____________________