Michael B. Lebowitz DDS PC
1277 E. Missouri Ave
Suite 205
Phoenix, AZ 85014

Doctor's Information

602-264-2905
602-297-6965 fax
drlebo@drlebo.net

Patient's Name

Last_____First_____Middle_____

Home Address _____ City_____State____ Zip_____

Home Phone_____Cell_____Work_____

e-mail_____Employer_____

Sex M☐ F☐ Soc Sec#_____-____-_____DOB___/___/____Occupation_____

Nickname_____ Single ☐ Married ☐ Divorced ☐

Billing information (if different than above)

Responsible Party

Last_____First_____Relationship_____

Billing address _____ City_____

State_____ zip_____ DOB ____/____/____

Employer_____Occupation_____

Insurance

Primary Insurance Carrier_____Plan ID_____

Referred by_____

Reason for Today's Visit: Routine Care ☐, Dental Pain ☐, Facial Pain ☐, Cosmetics ☐,

Consult ☐, Sleep Apnea ☐, Implants ☐, Invisalign ☐, Advanced Restorative ☐

Other_____

Date of Last Dental Visit _____ Date of last x-rays_____

Primary Care Physician_____

Address_____City_____State_____Zip_____

Phone #_____ Date of last physical_____/_____/_____

Emergency Contact Info:

Name of person to contact in case of emergency _____

Telephone_____Relationship_____

Financial Statement and Policy

Payment is expected as services are rendered.
We will gladly bill your dental insurance, however, ***patient portion is due at time of appointment***. We accept cash, check, Visa, MasterCard, Discover and American Express. If financing is needed for extensive treatment please let us help you with participating finance companies before treatment begins.

Medical and Dental History

	Y	N
1. Abnormal Bleeding	☐	☐
2. Anemia	☐	☐
3. Blood Disorders	☐	☐
4. Bruise Easily	☐	☐
5. Blood Transfusions	☐	☐
6. HIV AIDS	☐	☐
7. Hepatitis	☐	☐
8. Diabetes	☐	☐
9. Allergies	☐	☐
10. Hay Fever	☐	☐
11. Lung Disease, Valley Fever, TB	☐	☐
12. Asthma	☐	☐
13. Sinus or Nasal Obstruction	☐	☐
14. Difficulty Breathing	☐	☐
15. Emphysema	☐	☐
16. Heart or Chest pain	☐	☐
17. Mitral Valve Prolapse	☐	☐
18. Artificial Heart Valve	☐	☐
19. Heart Attack	☐	☐
20. Stroke	☐	☐
21. Heart Surgery	☐	☐
22. Pace Maker	☐	☐
23. High Blood Pressure	☐	☐
24. Low Blood Pressure	☐	☐
25. Frequent Swollen Ankles	☐	☐

	Y	N
25. Liver Disease	☐	☐
26. Convulsions, Fainting Spells	☐	☐
27. Psychiatric Problems	☐	☐
28. Kidney Problems	☐	☐
29. Thyroid Problems	☐	☐
30. Acid Reflux	☐	☐
31. Colitis	☐	☐
32. Glaucoma	☐	☐
33. Arthritis	☐	☐
34. Cancer, Chemotherapy	☐	☐
35. Radiation Therapy	☐	☐
36. Cosmetic Surgery	☐	☐
37. Fever Blisters	☐	☐
38. Sleep Apnea	☐	☐
39. Snoring	☐	☐
40. Difficulty Sleeping	☐	☐
41. Drug or Alcohol Addiction	☐	☐
42. Pain in the Jaw Joints	☐	☐
43. Ringing of the Ears	☐	☐
44. Frequent Headaches	☐	☐
45. Migraines	☐	☐
46. Clicking or Popping of Jaw	☐	☐
47. Difficulty Opening Jaw	☐	☐
48. Clenching or Grinding	☐	☐
49. Difficulty Chewing	☐	☐
50. Tooth sensitivity to Cold	☐	☐
51. Tooth Sensitivity to Hot	☐	☐

	Y	N	
Are you pregnant ?	☐	☐	Weeks___
Are you taking birth control pills	☐	☐	
Are you Nursing?	☐	☐	

Height Weight
BP / Heart Rate
Do you smoke or use Tobacco Y☐ N☐

Allergies	**Y**	**N**		**Y**	**N**	
Aspirin	☐	☐	Latex	☐	☐	Other:_____
Codeine	☐	☐	Jewelry	☐	☐	_____
Erythromycin	☐	☐	Metals	☐	☐	_____
Penicillin	☐	☐	Tetracycline	☐	☐	_____

Medications:

Is there any disease condition, or problem , that you think this office should know about that is not covered in the history provided above? Y☐ N☐ If yes please describe below…

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes to my medical status.

Signature_____ Date_____
Parent or Guardian's signature if a minor

Acknowledgement of Disclosure of Notice of Privacy Practices (HIPAA)
*****You may refuse to sign this HIPAA acknowledgement

Signature_____Date_____

Additional Notes

I verbally reviewed the medical/dental information above with patient named herein.
Doctors initials _____ Date _____

Submit Your Form