LEMAY FAMILY DENTISTRY

## Patient Information

Patient Name: ____________________________________________ ☐ Male ☐ Female
Last First MI

Address: ____________________________________________
Street Apartment #

____________________________________________
City State Zip Code

Social Security #: ______________________ Birth Date: ______________________

Best phone #: ______________________ Alternate #: ______________________

Email: ____________________________________________

Employer Name: ______________________ Occupation: ______________________

Address: ____________________________________________
Street City State Zip code

Who may we thank for referring you to our practice? ______________ Relationship to you? ______________

## Party Financially Responsible:

Name: ____________________________________________

Address: ____________________________________________

______________________ Phone: ______________________

Date of Birth: ______________________ Relationship to patient: ______________________

**If you have insurance, please provide proof of insurance, identification, and complete insurance work sheet.**

## Dental History

Reason for your visit today: ____________________________________________

Date of last dental visit: ______________________

*****Is there anything you would like to change about the condition of your mouth or appearance of your teeth?*****

____________________________________________

# Medical History

**Have you ever had any of the following? Please check those that apply:**

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due date: _________
- ☐ Radiation Treatment
- ☐ Tobacco Use
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

- Do you have any health problems not listed above? ☐ Yes ☐ No
  If yes, please explain: ____________________________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____________________________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____________________________________________
- Name of Physician: ______________________________ Phone: ____________

**Medications:** Please list all medications you are currently taking or provide a copied list:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Have you ever taken bone density medications / Bisphosphonates? (Fosamax, Actonel, Zometa, etc) Please list:

____________________________________________________________

Have you ever been told you need to take an antibiotic premedication prior to dental work? Please explain:

____________________________________________________________

**ALLERGIES:** Please list all known allergies you may have:

____________________________________________________________

**EMERGENCY CONTACT**: ____________________________________________

**PHONE #**: ____________________________________________

______________________________________________ Date: ________________
Signature of patient, parent or guardian

Relationship to Patient: ____________________________________________