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

How did you hear about our practice? _____

Party Financially Responsible:

(If same as above, please just put SELF)

Name: _____

Address: _____

_____ Phone: _____

Date of Birth: _____ Relationship to patient: _____

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?*****

_____

(OVER →)

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 #:

_____

PLEASE SIGN BELOW

_____

Patient, Parent, or Guardian Signature Date

_____

Relationship to Patient