LEMAY FAMILY DENTISTRY

Patient Information

Patient Name: _____ ☐ Male ☐ Female
Last First MI

Address: _____
Street Apartment #

_____
City State Zip Code

Social Security #: _____ Birth Date:_____

Cell Phone #: _____ Home/Alternate #: _____

Email: _____

Employer Name: _____ Occupation: _____

Emergency Contact: _____

Emergency Contact Phone #: _____ Relationship to patient: _____

How did you hear about our practice? _____

Party Financially Responsible

(If same as above, please write 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? ****

_____

(TURN OVER →)

Medical History

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

- O AIDs
- O Alzheimer's
- O Anemia
- O Anxiety
- O Artificial Joints
- O Asthma
- O Blood Disease
- O Cancer
- O Cold Sores/Fever Blisters
- O Depression
- O Diabetes, Type I
- O Diabetes, Type II
- O Dizziness
- O Epilepsy
- O Excessive Bleeding
- O Fainting
- O Glaucoma
- O Hay Fever
- O Head Injuries
- O Heart Disease
- O Heart Murmur
- O Hepatitis Type: _____
- O High Blood Pressure
- O HIV
- O Jaundice
- O Kidney Disease
- O Liver Disease
- O Mental Disorders
- O Nervous Disorders
- O Organ Transplant
- O Osteoarthritis
- O Pacemaker
- O Pregnancy Due Date: _____
- O Radiation Treatment
- O Respiratory Problems
- O Rheumatoid Arthritis
- O Sinus Problems
- O Sleep Apnea
- O Stomach Problems
- O Stroke
- O Tobacco Use
- O Tuberculosis
- O Tumors
- O Ulcers
- O Vaping
- O 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:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: Please list all known allergies you may have:

_____

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:

_____

PLEASE SIGN BELOW

_____ Date: _____
Patient, Parent, or Guardian Signature

_____
Relationship to Patient