PATIENT REGISTRATION

Welcome! *Please complete the following confidential information*

PATIENT INFORMATION

NAME _____
(First) (Middle) (Last)

WHO MAY WE THANK FOR REFERRING YOU TO US? _____

SOCIAL SECURITY # _____ DATE OF BIRTH (MONTH / DAY / YEAR) _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

E-MAIL _____

EMPLOYER: _____ WORK PHONE _____ EXT _____

RELATIONSHIP TO INSURANCE SUBSCRIBER (The person in your family who your insurance is through): ☐ Self ☐ Spouse ☐ Child ☐ Other

PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____ GROUP/POLICY # _____

NAME OF SUBSCRIBER _____ SOCIAL SECURITY # _____
(First) (Middle) (Last)

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

DATE OF BIRTH _____ MARITAL STATUS: ☐ Married ☐ Single ☐ Other WORK PHONE _____ EXT _____

EMPLOYER _____ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

SECONDARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____ GROUP/POLICY # _____

NAME OF SUBSCRIBER _____ SOCIAL SECURITY # _____
(First) (Middle) (Last)

DATE OF BIRTH _____ MARITAL STATUS: ☐ Married ☐ Single ☐ Other WORK PHONE _____ EXT _____

EMPLOYER _____ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

CONSENT:

1. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**: By signing below I acknowledge that I have received and reviewed a copy of this office's Notice of Privacy Practices according to federal and state requirements and I consent to the use of my records and information to carry out treatment, payment activities, and health care operations as set forth in this office's Privacy Notice.
2. I hereby authorize Dr. Bronislaw B. Lemaitre or designated staff to take X-rays, photographs and any other diagnostic aids deemed appropriate by Dr. Bronislaw Lemaitre to make a thorough diagnosis of my dental needs. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated.
3. **I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Dr. Bronislaw B. Lemaitre. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the Dr. Lemaitre has a contractual agreement with my plan prohibiting all or a portion of such charges**.
4. By signing below, **I certify that I fully understand, and agree to the above items**.

Patient/Guardian's Signature _____ **Date** _____

(OVER)

MEDICAL HISTORY

Welcome! *So that we may provide you with the best possible care, please complete both sides of this medical and dental history form. All information is completely confidential.*

PATIENT'S NAME: _____

Have you been under the care of a medical doctor during the past two years? ..... Yes No
If yes, for what? _____
Physician's Name _____ Telephone _____
Address _____ City _____ State _____ Zip _____

Are you currently taking any medications, drugs or pills? ..... Yes No
If yes, please list name and dosage: _____
_____

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? ..... Yes No
If yes, please list: _____

Circle Yes or No to indicate whether or not you have had or now have the following conditions or treatments:

Heart Condition ..... Yes / No	Contact Lenses ..... Yes / No	Cortisone Medicine ..... Yes / No
Heart Attack ..... Yes / No	Glaucoma ..... Yes / No	Arthritis/Rheumatism ..... Yes / No
Heart Surgery ..... Yes / No	Bruise Easily ..... Yes / No	Fen-Phen or Redox..... Yes / No
Chest Pain (Angina) ..... Yes / No	Emphysema ..... Yes / No	Special or Restricted Diet ..... Yes / No
Congenital Heart Disease ..... Yes / No	Chronic Cough ..... Yes / No	Latex Sensitivity ..... Yes / No
Stroke ..... Yes / No	Tuberculosis (T.B.) ..... Yes / No	Cancer ..... Yes / No
High Blood Pressure ..... Yes / No	Asthma ..... Yes / No	Tumors ..... Yes / No
Mitral Valve Prolapse ..... Yes / No	Hay Fever ..... Yes / No	Chemotherapy ..... Yes / No
Artificial Heart Valve ..... Yes / No	Sinus Trouble ..... Yes / No	Radiation Therapy ..... Yes / No
Rheumatic Fever ..... Yes / No	Allergies or Hives ..... Yes / No	Neurological Disorders ..... Yes / No
Heart Murmur ..... Yes / No	Liver Disease ..... Yes / No	Nervous/Anxious ..... Yes / No
Heart Pacemaker ..... Yes / No	Hepatitis Type ____ ..... Yes / No	Epilepsy or Seizures ..... Yes / No
Anemia ..... Yes / No	Yellow Jaundice ..... Yes / No	Fainting or Dizzy Spells ..... Yes / No
Hemophilia ..... Yes / No	AIDS ..... Yes / No	Psychiatric/Psychological Care .. Yes / No
Ulcers ..... Yes / No	HIV Positive ..... Yes / No	Kidney Trouble ..... Yes / No
Alcoholism ..... Yes / No	Venereal Disease ..... Yes / No	Artificial Joints or Heart Valves... Yes / No
Drug Addiction ..... Yes / No	Cold Sores/Fever Blisters ..... Yes / No	Sickle Cell Disease ..... Yes / No
Diabetes ..... Yes / No	Blood Transfusion ..... Yes / No	Osteoporosis..... Yes / No
Family History of Diabetes ..... Yes / No	Thyroid Problems ..... Yes / No	Bone Disease or Bone Cancer... Yes / No
	Swollen Ankles ..... Yes / No	

Do you have or have you had any disease, condition or problem not listed ..... Yes No
If yes, please list: _____

Have you ever had prolonged or unusual bleeding? ..... Yes No

Have you ever had a reaction to a local anesthetic? ..... Yes No

Do you experience frequent thirst, frequent eating or frequent urination? ..... Yes No

Women: Are you pregnant?…Yes No If yes, due date: _____ Nursing?…Yes No Taking birth control pills?…Yes No

Patient/Guardian's Signature _____ **Date** _____

(OVER)

DENTAL HISTORY

CURRENT GENERAL DENTIST _____

DATE OF LAST DENTAL VISIT _____ LAST DENTAL CLEANING _____ LAST FULL MOUTH X-RAYS _____

HOW OFTEN DO YOU HAVE DENTAL EXAMINATIONS? _____Seldom _____ Less than annually _____ Annually _____ Twice Annually or More

HOW OFTEN DO YOU BRUSH YOU TEETH? _____ HOW OFTEN DO YOU FLOSS? _____

WHAT OTHER DENTAL AIDS DO YOU USE? (Mouthrinse, toothpick, etc.) _____

Have you ever had:

Periodontal Treatment (deep cleaning or gum surgery)? ..... Yes No..... If yes, when? _____

Oral Surgery (tooth removal)? ..... Yes No

Orthodontic Treatment (braces)? ..... Yes No ..... If yes, when? _____

Your teeth ground or the bite adjusted? ..... Yes No

A bite plate or mouth guard? ..... Yes No

Do you smoke or chew tobacco? ..... Yes No..... If yes, how much? _____

Do you clench or grind your teeth while awake or asleep? ..... Yes No

Has any of your family members experienced periodontal

disease (such as gum disease or gingivitis)? ..... Yes No..... If yes, which family members? _____

Have you noticed any loose teeth or a change in your bite? ..... Yes No _____

Do you mouth-breathe while awake or asleep? ..... Yes No

Does food tend to become caught in between your teeth? ..... Yes No..... If yes, where? _____

Do you have tired jaws, especially in the morning?..... Yes No _____

Do you regularly experience clicking, popping or pain in the jaw joints?..... Yes No

Do you have difficulty in opening or closing your mouth? ..... Yes No

Do you chew on objects such as pencils or bite your nails? ..... Yes No..... If yes, what objects? _____

Would you like to keep all of your teeth all of your life? ..... Yes No

Do you feel nervous about having dental treatment? ..... Yes No..... If yes, what is your main concern? _____

_____

Have you ever had an upsetting dental experience? ..... Yes No..... If yes, please describe: _____

_____

Have you ever been told you need to take premedication prior to dental treatment? _____

Please explain anything else about having dental treatment that you would like us to know? _____

_____

_____

I understand that my medical and dental histories are necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, Dr. Bronislaw B. Lemaitre has my permission to ask the respective health care provider or agency, who may release such information to Dr. Lemaitre. I will notify Dr. Lemaitre of any change in my health and/or medication(s).

Patient/Guardian's Signature _____ **Date** _____

(OVER)