

Welcome!

REGISTRATION FORM

Section I: (Please Print)

Patient Information

Name: _____ I Prefer to be called: _____

Check Appropriate Box: Minor Single Married Other _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip _____

Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

The best time to contact me is: _____ on my Home phone Work phone Cell phone

Email Address _____ Would you like to receive our e-newsletter? Yes No

Patient Employer/School _____ Occupation _____ FT PT

Spouse or Parent's Name: _____ Employer _____ Wk Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Section II

Responsible Party

Relationship to Patient: Self Spouse Parent Other

Name: _____ Phone: _____

Section III

Dental Insurance Information

Name of Policy-holder _____ DOB _____ Relationship to Patient _____

SSN#: _____ Name of Employer: _____ Work Phone: (____) _____

Address of Employer: _____ City _____ State: _____ Zip _____

Insurance Company _____ Grp # _____ ID# _____

Ins Co Address: _____ Ins Co. Phone: _____

----- DO YOU HAVE ADDITIONAL DENTAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING -----

Name of Policy-holder _____ DOB _____ Relationship to Patient _____

SSN#: _____ Name of Employer: _____ Work Phone: (____) _____

Address of Employer: _____ City _____ State: _____ Zip _____

Insurance Company _____ Grp # _____ ID# _____

Ins Co Address: _____ Ins Co. Phone: _____

Section V Medical History

Your Physical Health is: GOOD FAIR POOR

Physician's Name: _____

Phone #: _____ Last visit _____

List all medications you currently take (or attach list):

Check if you are allergic or sensitive to the following:

- | | |
|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Dental anesthetic | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sensitivity to metals |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Sensitivity to latex |
- _____
- _____

Check if you have ever had any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Rheumatic or Scarlet Fever |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Heart Defect | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Other conditions (please explain): | |

For women only:

- Are you pregnant? YES NO
- Are you nursing? YES NO
- Do you take birth control pills?
 YES NO

Section V: Dental History

Previous Dentist: _____

Phone #: _____ Last visit _____

Reason for today's visit:

How often do you: BRUSH? _____
FLOSS? _____

Do you like your smile? YES NO

Check any of the following conditions that apply to you:

- | | |
|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Clicking/popping Jaw | <input type="checkbox"/> Food collecting in teeth |
| <input type="checkbox"/> Grinding at night | <input type="checkbox"/> Loose or broken teeth |
| <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity to cold or heat |
| <input type="checkbox"/> Mouth sores/growths | <input type="checkbox"/> Sensitivity to biting pressure |
| <input type="checkbox"/> Injuries to mouth/head | <input type="checkbox"/> Unpleasant dental visits |
| <input type="checkbox"/> Any mouth-related habits? (explain): | |

Do you use any form of tobacco? YES NO

Section VI Certification and Assignment

*To the best of my knowledge, the information provided here is complete and correct. I understand that it is my responsibility to inform Dr. Lemieux and staff of any change in health.

*I authorize the dental staff to perform necessary services, with my informed consent, that I may need during diagnosis and treatment.

*I am financially responsible for all charges, whether or not paid by insurance.

*I certify and assign directly to Dr. Steven B. Lemieux any and all insurance benefits otherwise payable to me for services rendered.

*I understand that in the case of a delinquent account, collections and/or legal fees may be added to my account.

*I give my consent for Dr. Lemieux and staff to disclose my health care information to my insurance company and their agents for the purpose of determining insurance benefits or obtaining payment for services.

*I approve the use of my signature on all insurance submissions.

Signature of Patient, Parent, Guardian

Date: _____