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_____

E-mail Address: _____

Phone (_____) _____ Work phone (_____) _____ **Cell phone** (_____) _____

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

Patient Employer/School_____ Occupation _____ ☐ FT ☐ PT

Spouse's or parent's name: _____ Employer_____ Phone_____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone_____

Section II: **Responsible Party**

The responsible party's relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

If other than self, please complete the following:

Name: _____ Phone: _____

Address: _____

Section III: **Dental Insurance Information**

Policy-holder Name _____DOB_____Relationship to Patient _____
Address: _____City_____State:_____Zip _____
SSN#:_____ Name of Employer: _____ Work Phone: (____)_____
Insurance Company_____ Group #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone: _____

--- DO YOU HAVE A 2nd DENTAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ---

Policy-holder Name _____DOB_____Relationship to Patient _____
Address: _____City_____State:_____Zip _____
SSN#:_____ Name of Employer: _____ Work Phone: (____)_____
Insurance Company_____ Group #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

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Section V: Medical History

Your Physical Health is: ☐ GOOD ☐ FAIR ☐ POOR

Physician's Name: _____

Phone #: _____ Last visit _____

List all prescription or over-the-counter medications you currently take (or attach list):

_____

_____

Check if you are allergic or sensitive to the following:

☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Dental anesthetic	☐ Tetracycline
☐ Erythromycin	☐ Sensitivity to latex
☐ Ibuprofen	☐ Sensitivity to metals
☐ Other:	

_____

Have you ever been told you need to take an antibiotic prior to your dental visits? ☐ YES ☐ NO

Check if you have ever had any of the following:

☐ Abnormal Bleeding	☐ High Blood Pressure
☐ Anemia	☐ HIV or AIDS
☐ Arthritis	☐ Kidney Disease
☐ Artificial Heart Valve	☐ Low Blood Pressure
☐ Artificial Joint	☐ Liver Disease
☐ Asthma	☐ Mitral Valve Prolapse
☐ Bacterial Endocarditis	☐ Pacemaker
☐ Cancer	☐ Pulmonary Embolism
☐ Chemotherapy	☐ Radiation Treatment
☐ Diabetes	☐ Respiratory Problem
☐ Eating Disorder	☐ Rheumatic or Scarlet Fever
☐ Epilepsy/Seizures	☐ Sinus Problem
☐ Heart Attack	☐ Stroke
☐ Heart Defect	☐ Substance Abuse
☐ Heart Murmur	☐ Thyroid Problem
☐ Heart Problem	☐ Tuberculosis (TB)
☐ Hepatitis	☐ Ulcer or GI Problem

☐ 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:

☐ Bad breath	☐ Bleeding gums
☐ Clicking/popping jaw	☐ Food collecting in teeth
☐ Grinding at night	☐ Loose or broken teeth
☐ Periodontal treatment	☐ Sensitivity to cold or heat
☐ Mouth sores/growths	☐ Sensitivity to biting pressure
☐ Injuries to mouth/head	☐ Unpleasant dental visits

☐ 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: _____