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:____________________________

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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:

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

____

____

Check if you have ever had any of the following:

☐ Abnormal Bleeding ☐ High Blood Pressure
☐ Anemia ☐ HIV or AIDS
☐ Arthritis ☐ Kidney Disease
☐ Artificial Heart Valves ☐ Low Blood Pressure
☐ Artificial Joints ☐ Liver Disease
☐ Asthma ☐ Mitral Valve Prolapse
☐ Cancer ☐ Pacemaker
☐ Chemotherapy ☐ Radiation Treatment
☐ Diabetes ☐ Respiratory Problems
☐ Epilepsy/Seizures ☐ Rheumatic or Scarlet Fever
☐ Heart Attack ☐ Sinus Problems
☐ Heart Defect ☐ Stroke
☐ Heart Murmur ☐ Thyroid Problems
☐ Heart Problems ☐ Tuberculosis (TB)
☐ Hepatitis ☐ Ulcer
☐ 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:_____________________________