

PATIENT REGISTRATION

Welcome! Please complete the following confidential information

PATIENT INFORMATION

NAME			 .				
(First)		(Mic	ddle)		(Last)		
WHO MAY WE THANK FOR	R REFERRI	NG YOU TO US?					
SOCIAL SECURITY #		DA1	E OF B	BIRTH (MONTH / DAY / YEAR)			
STREET ADDRESS							
CITY		STATE	_ ZIP		PHONE		
E-MAIL							
EMPLOYER:			wc	ORK PHONE		EXT	
RELATIONSHIP TO INSUR	ANCE SUB	SCRIBER (The person in your fami	ly who y	our insurance is throug	h): Í Self Í Spouse	Í Child Í Other	
PRIMARY DENTAL INS	URANCE	INFORMATION:					
NAME OF INSURANCE CC	MPANY:				_ GROUP/POLICY #	ŧ	
NAME OF SUBSCRIBER _					SOCIAL SECU	JRITY #	
	(First)	(Middle)		(Last)			
STREET ADDRESS		·····					
CITY		STATE	_ ZIP	I	HOME PHONE		
DATE OF BIRTH		_ MARITAL STATUS: 1 Married 1	Single	Î Other WORK PHON	E	EXT	
EMPLOYER			FU	LL-TIME OR PART-TIN	IE EMPLOYEE (Circl	e One)	
SECONDARY DENTAL	INSURAN	CE INFORMATION:					
NAME OF INSURANCE CC	MPANY:				GROUP/POLICY #	ŧ	
NAME OF SUBSCRIBER							
	(First)	(Middle)		(Last)			
DATE OF BIRTH		_ MARITAL STATUS: Married	Single	Í Other WORK PHON	Ε	<u> </u>	
EMPLOYER			FU	LL-TIME OR PART-TIN	IE EMPLOYEE (Circl	e 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*.



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.

If yes, for what? Yes Yes Physician's Name	Have you been under the care of a medical docto	or during the past two ye	ars?			Yes N
Are you currently taking any medications, drugs or pills? Yes I If yes, please list name and dosage:	II yes, for what?		Telenhone			
Are you currently taking any medications, drugs or pills? Yes I If yes, please list name and dosage:	Address	City		State	Zin	
Are you currently taking any medications, drugs or pills? Yes I If yes, please list name and dosage:	//dd/000	Oity _			<u>Z</u> ıp	
If yes, please list:	Are you currently taking any medications, drugs on If yes, please list name and dosage:	or pills?				Yes N
Heart Condition Yes / No Contact Lenses Yes / No Cortisone Medicine Yes / No Heart Attack Yes / No Bruise Easily Yes / No Arthritis/Rheumatism Yes / No Heart Surgery Yes / No Emphysema Yes / No Fen-Phen or Redox Yes / No Congenital Heart Disease Yes / No Chronic Cough Yes / No Special or Restricted Diet Yes / No Stroke Yes / No Asthma Yes / No Cancer Yes / No Mitral Valve Prolapse Yes / No Asthma Yes / No Chemotherapy Yes / No Artificial Heart Valve Yes / No Asthma Yes / No Chemotherapy Yes / No Rheumatic Fever Yes / No Allergies or Hives Yes / No Nervous/Anxious Yes / No Heart Murmur Yes / No Allergies or Hives Yes / No Release Yes / No Nervous/Anxious Yes / No Heart Pacemaker Yes / No Heapatitis Type Yes / No Fainting or Dizzy Spells Yes / No Heart Pacemaker Yes / No Heapatitis Type Yes / No Ro Fainting or Dizzy Spells						
Heart Attack Yes / No Glaucoma Yes / No Arthritis/Rheumatism Yes / No Heart Surgery Yes / No Emil (Angina) Yes / No Emile Angina) 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 Attima Yes / No Tumors Yes / No Miral Valve Prolapse Yes / No Hay Fever Yes / No Radiation Therapy Yes / No Artificial Heart Valve Yes / No Allergies or Hives Yes / No Neurological Disorders Yes / No Heart Murmur Yes / No Liver Disease Yes / No Palentagey or Seizures Yes / No Heart Pacemaker Yes / No Yelow Jaundice Yes / No Fainting or Dizzy Spells Yes / No Heart Murmur Yes / No Allos Yes / No Paleotypey or Seizures Yes / No	Circle Yes or No to indicate whether or not you ha	ave had or now have the	e following condition	s or treatments:		
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 Tuberculosis (T.B.) Yes / No Latex Sensitivity Yes / No High Blood Pressure Yes / No Astma Yes / No Cancer Yes / No Mitral Valve Prolapse Yes / No Astma Yes / No Chemotherapy Yes / No Artificial Heart Valve Yes / No Astma Yes / No Chemotherapy Yes / No Returnatic Fever Yes / No Alargies or Hives Yes / No Nervous/Anxious Yes / No Heart Murmur Yes / No Liver Disease Yes / No Nervous/Anxious Yes / No Heart Murmur Yes / No Hepatilis Type Yes / No Fainting or Dizzy Spells Yes / No Heart Murmur Yes / No Allos Yes / No Fainting or Dizzy Spells Yes / No Ucers Yes / No Allos Yes / No Fainting or Dizzy Spells Yes / No Uleres <th>Heart Condition Yes / No</th> <th>Contact Lenses</th> <th>Yes / No</th> <th></th> <th></th> <th></th>	Heart Condition Yes / No	Contact Lenses	Yes / No			
Chest Pain (Ångina) Yes / No Emphysema Yes / No Special or Restricted Diet Yes / No Congenital Heart Disease Yes / No Tuberculosis (T.B.) Yes / No Latex Sensitivity Yes / No Stroke Yes / No Tuberculosis (T.B.) Yes / No Cancer Yes / No Mitral Valve Prolapse Yes / No Hay Fever Yes / No Chemotherapy Yes / No Artificial Heart Valve Yes / No Sinous Trouble Yes / No Reumatic Fever Yes / No Rheumatic Fever Yes / No Allergies or Hives Yes / No Neurological Disorders Yes / No Heart Murmur Yes / No Liver Disease Yes / No Epilepsy or Seizures Yes / No Anemia Yes / No Heart Bacemaker Yes / No Heart Disease Yes / No Fainting or Dizzy Spells Yes / No Ulcers Yes / No HIV Positive Yes / No Heart Seinting or Dizzy Spells Yes / No Diabetes Yes / No Cold Sores/Fever Bisters Yes / No Sickle Cell Disease Yes / No Diabetes Yes / No Thyroid Problems Yes / No <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
Congenital Heart Disease Yes / No Chronic Cough Yes / No Latex Sensitivity Yes / No Stroke Yes / No Asthma Yes / No Cancer Yes / No Migh Blood Pressure Yes / No Asthma Yes / No Cancer 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 Renematic Fever Yes / No Allergies or Hives Yes / No Neurological Disorders Yes / No Heart Murmur Yes / No Liver Disease Yes / No Neurological Disorders Yes / No Heart Pacemaker Yes / No Hepatitis Type Yes / No Fainting or Dizzy Spells Yes / No Heart Pacemaker Yes / No AlDS Yes / No Fainting or Dizzy Spells Yes / No Ucers Yes / No Vellow Jaundice Yes / No Fainting or Dizzy Spells Yes / No Ulcers Yes / No Olisease Yes / No Vellow Jaundice Yes / No Sickle Cell Disease Ye	Heart SurgeryYes / 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 Allergies or Hives Yes / No Relation Therapy Yes / No Rheumatic Fever Yes / No Liver Disease Yes / No Nervous/Anxious Yes / No Heart Murmur Yes / No Hiver Disease Yes / No Nervous/Anxious Yes / No Heart Pacemaker Yes / No Heighelitis Type Yes / No Epilepsy or Sizures Yes / No Allos Mitral Yes / No Allos Yes / No Fainting or Dizy Spells Yes / No Ulcers Yes / No Allos Yes / No Yes / No Cold Sores/Fever Blisters Yes / No Sickle Cel Disease Yes / No		Emphysema	Yes / No	Special or Re	stricted Diet	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 Allergies or Hives Yes / No Radiation Therapy Yes / No Heart Murmur 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 Radiation Therapy Yes / No Hemophilia Yes / No Heint Pacemaker Yes / No Hive Positive Yes / No Ucers Yes / No Allos Yes / No Psychiatric/Psychological Care Yes / No Diabetes Yes / No HiV Positive Yes / No Sickle Cell Disease Yes / No Diabetes Yes / No Blood Transfusion Yes / No Sickle Cell Disease or Bone Cancer Yes / No Do you have or have you had any disease, condition or problem not listed Yes / No Bone Disease or Bone Cancer Yes / No Have yo						
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 Nervous/Anxious Yes / No Anemia Yes / No Yes / No Hepatitis Type Yes / No Psinting or Dizzy Spells Yes / No Heart Pacemaker Yes / No Yes / No Yes / No Yes / No Psichatric/Psychological Care . Yes / No Heart Social Yes / No HIV Positive Yes / No No Psichatric/Psychological Care . Yes / No Ulcers Yes / No Cold Sores/Fever Blisters Yes / No Sickle Cell Disease Yes / No Diabetes Yes / No Thyroid Problems Yes / No Socleaporosis Yes / No If yes, please list:						
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 Revous/Anxious Yes / No Anemia Yes / No Yes / No Hepatitis Type Yes / No Revous/Anxious Yes / No Anemia Yes / No Yes / No Yellow Jaundice Yes / No Fainting or Dizzy Spells Yes / No Hemophilia Yes / No AlDS Yes / No Psychiatric/Psychological Care . Yes / No Ulcers Yes / No Venereal Disease Yes / No Kidney Trouble 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 Do you have or have you had any disease, condition or problem not listed Yes / No Bone Disease or Bone Cancer Yes						
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 Anemnia Yes / No Yes / No Hepatitis Type Yes / No Fainting or Dizzy Spells Yes / No Hemophilia Yes / No AlDS 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 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 Do you have or have you had any disease, condition or problem not listed Yes / No Yes I Yes I Have you ever had prolonged or unusual bleeding? Yes I Yes I Yes I		5				
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 AlDS Yes / No Fainting or Dizzy Spells Yes / No Ulcers Yes / No HIV Positive Yes / No Psychiatric/Psychological Care Yes / No Alcoholism Yes / No HIV Positive Yes / No Kidney Trouble 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 Do you have or have you had any disease, condition or problem not listed Yes / No Yes I Yes I Have you ever had prolonged or unusual bleeding? Have you ever had a reaction to a local anesthetic? Yes I <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
Heart Pacemaker Yes / No Hepatitis TypeYes / 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 Psychiatric/Psychological Care . Yes / No Ulcers Yes / No HIV Positive Yes / No Psychiatric/Psychological Care . 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 Family History of Diabetes Yes / No Thyroid Problems Yes / No Blood Transfusion Yes / No Bone Disease or Bone Cancer Yes / No Do you have or have you had any disease, condition or problem not listed Yes / No Yes / Yes / If yes, please list:						
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 Sickle Cell Disease Yes / No Family History of Diabetes Yes / No Thyroid Problems Yes / No Bone Disease or Bone Cancer Yes / No Do you have or have you had any disease, condition or problem not listed Yes / No Yes / No If yes, please list:						
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 Sickle Cell Disease Yes / No Family History of Diabetes Yes / No Thyroid Problems Yes / No Bone Disease or Bone Cancer Yes / No Do you have or have you had any disease, condition or problem not listed Yes / No Yes / No If yes, please list:		Hepatitis Type	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 Sickle Cell Disease Yes / No Family History of Diabetes Yes / No Thyroid Problems Yes / No Bone Disease or Bone Cancer Yes / No Do you have or have you had any disease, condition or problem not listed Yes / No Yes / No Yes / No Have you ever had prolonged or unusual bleeding? Yes / Yes / Yes / Have you ever had a reaction to a local anesthetic? Yes / Yes /						
Alcoholism Yes / No Venereal Disease Yes / No Artificial Joints or Heart ValvesYes / 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 Do you have or have you had any disease, condition or problem not listed Yes / No Yes / No If yes, please list:	•					
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 Do you have or have you had any disease, condition or problem not listed Yes / No Yes / Yes / If yes, please list:						
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 Do you have or have you had any disease, condition or problem not listed Yes / No Yes / No If yes, please list:						
Family History of Diabetes Yes / No Thyroid Problems						
Swollen Ankles Yes / No Do you have or have you had any disease, condition or problem not listed Yes / I If yes, please list: Yes /				•		
Do you have or have you had any disease, condition or problem not listed	Family History of Diabetes Yes / No			Bone Disease	e or Bone Cancer	Yes / No
Have you ever had a reaction to a local anesthetic?		tion or problem not listed	d t			Yes N
Have you ever had a reaction to a local anesthetic?						
		-				
Do you experience frequent thirst, frequent eating or frequent urination?						
	Do you experience frequent thirst, frequent eating	or frequent urination? .				Yes N

Patient/Guardian's Signature ____

Date ___



DENTAL HISTORY

CURRENT GENERAL DENTIST				
DATE OF LAST DENTAL VISIT LAST DENTAL CLEANIN	NG 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?				
Have you ever been told you need to take premedication prior to dental	treatment?			
Please explain anything else about having dental treatment that you wo	uld 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 _____