

Leon Springs Family Dental

Welcome.

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Name: _____ SSN: _____ - _____ - _____

Address: _____

City: _____ St: _____ Zip: _____

D.O.B. ____/____/____ Home #: (____) - ____ - ____ Mobile: (____) - ____ - ____

Minor: _____ Single: _____ Married: _____ Divorced: _____ Widowed: _____

Patient Employer: _____ Work Phone: (____) - ____ - ____

Email: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____

Relationship to patient: _____ Phone: (____) - ____ - ____

Responsible Party

Name of person responsible for this account: _____

Policy Holder: _____ Relationship to patient: _____

Address: _____ Home Phone: (____) - ____ - ____

D.O.B. ____/____/____ SSN: _____ - _____ - _____

Employer: _____ Work Phone: (____) - ____ - ____

Insurance Name: _____ Group Number: _____

Address: _____ Phone: (____) - ____ - ____

Do you have any additional insurance? YES / NO If yes, complete the following:

Policy Holder: _____ Address: _____

Home #: (____) - ____ - ____ D.O.B. ____/____/____ SSN: _____ - _____ - _____

Employer: _____ Work Phone: (____) - ____ - ____

Insurance Name: _____ Group Number: _____

Address: _____ Phone: (____) - ____ - ____

For your convenience we offer the following methods of payment:
Cash * Personal Checks * Visa * MasterCard * American Express

Dental History

Patient Name: _____ Date: _____

Reason for today's visit: _____ Date of last dental care: _____

Former Dentist (optional): _____ Date of last dental x-rays: _____

Check (✓) if you have had any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity to biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores in mouth |

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name: _____ Date of last visit: _____

Have you had any serious illnesses or operations? _____ If yes, describe: _____

_____ Have you ever taken fen-phen: YES / NO

(Women) Are you pregnant? Yes No Nursing Yes No Birth control pills Yes No

Check (✓) if you have or have had any of the following: Please check appropriate boxes. If yes to any of the starred (*) conditions, pre-medication may be required.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis/ Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Artificial heart valves * | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Artificial Joints * | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of limbs |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse * | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker * | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart murmur * | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Venereal disease |

Medications: List all medications you are currently taking: _____

Pharmacy Name: _____ Phone: (____) - ____ - _____

Allergies:

- | | | | | | |
|----------------------------------|---------------------------------------|----------------------------------|---|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local anesthetic | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Other: _____ | | | | |

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of their staff responsible for any errors or omissions that I may have made in completion of this form.

Date: _____ Signature: _____

Date: _____ Dr. Signature: _____