Leroy Dental Center
20 Lake Street
LeRoy, NY 14482

Pavilion Dental Center
6932 Cato Street
Pavilion, NY 14525

Patient Information (Confidential)

Name:_____ Date: _____

Social Security #:_____ Date of Birth: _____ Home Phone: _____

Cell Phone: _____ Address: _____

Referred by: _____ Family Members That Are Patients: _____

Employer Information

Employer Name: _____ Position: _____
Length of Time at Current Employer: _____

Responsible Party

Person Responsible for account:_____ Relationship to Patient: _____

Social Security # _____ Date of Birth: _____ Phone : _____

Address: _____

Primary Insurance: _____ Employer: _____

ID Number: _____ Group Number: _____ Ins . Phone Number: _____

Claim Address: _____

Secondary Insurance: _____ Employer: _____

Insured person:_____ Relationship to Patient: _____

Social Security # _____ Date of Birth: _____ Phone : _____

ID Number: _____ Group Number: _____ Ins . Phone Number: _____

Claim Address: _____

Medical History

Name & Phone # of Physician: _____
General Health : ___ Excellent ___ Good ___ Fair ___ Poor
Are you now under the care of a physician? …… Yes_____ No _____
If Yes, for what reason or condition? _____
Are you taking any medication now? ……...Yes_____ No_____
If Yes, please name the medications: _____
Do you smoke? ……Yes_____ No _____

Have You Ever Been Treated For: Please Circle

Heart Disease	Blood Disorders	Heart Murmur	Heart Surgery
Anemia	Kidney Problems	Diabetes	Congenital Heart Lesions
Glaucoma	Arthritis	Sinus Trouble	Cancer
Rheumatic Fever	Lung Disorder	Rheumatic Heart Disease	Tuberculosis
ARC- HIV Positive	AIDS	Fainting Spells	High Blood Pressure
Low Blood Pressure	Angina	Thyroid Disease	Mitral Valve Prolapse
Liver Disease	Venereal Disease	Hepatitis	Artificial Joints
Stroke	Allergies	Asthma	Hayfever
Seizure Disorder (Epilepsy)	Psychiatric Problems		

List any diseases or conditions not listed above: _____
Have you had excessive or prolonged bleeding associated with previous extractions, surgery or trauma? Yes__ No__
Do you bruise easily?……Yes_____ No_____
Have you required a blood transfusion? ……...Yes_____ No_____

Are you allergic to Penicillin___, Other Antibiotics___, Local Anesthetics___, Aspirin_____, Codeine_____
Latex_____
Any other medication: _____

Women Only

Are you pregnant?..... Yes_____ No_____
Are you taking birth control?..... Yes_____ No_____

Dental Health

Chief Complaint: _____

When and where was your last dental visit?_____

Do you visit the dentist regularly? Yes___ No___

Have you ever been treated for **periodontal disease**? Yes___ No___ If yes, when: _____

Have you ever had serious problems associated with previous dental treatment? …… Yes__ No___

If yes, explain:_____

How often do you brush your teeth? _____ How often do you floss? _____
Do you experience dry mouth (Xerostomia)? Yes____ No____
Do your gums feel tender or swollen? Yes____ No____
Do your gums bleed while brushing or flossing? Yes____ No____
What texture toothbrush do you use? _____
Do you avoid brushing or flossing areas due to pain? Yes____ No____
Does food catch between teeth? Yes____ No____
Do you chew on only one side of your mouth? Yes____ No____
Do you clench or grind your teeth? Yes____ No____
Are any teeth sensitive to hot, cold or pressure? Yes____ No____
Do you feel your teeth are affecting you health? Yes____ No____
Have you ever had professional advice in dental home care? Yes____ No____
Are you satisfied with the appearance of your teeth? Yes____ No____
If no explain: _____

Do you wear full dentures? Yes____ No____ Upper ____ Lower ____ Approximate date made: _____

Do you wear partial dentures? Yes___ No___ Upper ____ Lower____ Approximate date made_____

Do you have retention problems with dentures or partials? Yes_____ No____

Do you gag easily? Yes_____ No____

Are you apprehensive (nervous) about your dental treatment? Yes_____ No____

Please add anything you feel is important:

_____

_____

Consent:

The undersigned hereby authorizes the Doctor to perform all necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patients' dental or oral – facial needs including x-rays, study models, photographs, medications and the use of local anesthetic agents. ANY CHANGE IN HEALTH OR MEDICATION WILL PROMPTLY NOTIFIED TO THE DENTIST.

Patient Signature (Parent of Child) Date

Dentist Signature Date