

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