

LeFleur Dental Group
1437 Old Square Road, Suite 105
Jackson, MS 39211

PATIENT INFORMATION

DATE _____

NAME _____

ADDRESS _____
(STREET) (APT#) (CITY) (STATE) (ZIP)

HOME PHONE NUMBER () _____ OFFICE PHONE NUMBER () _____

EMAIL ADDRESS _____ CELL NUMBER () _____

DATE OF BIRTH _____ PLACE OF BIRTH _____ SEX _____ MARITAL STATUS _____

PATIENT'S SOCIAL SECURITY NUMBER _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____

PERSON RESPONSIBLE FOR PATIENT ACCOUNT _____

ADDRESS _____ PHONE NUMBER () _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

IF PATIENT IS A CHILD MOM'S NAME _____ FATHER'S _____

HOW DOES THE RESPONSIBLE PERSON PLAN TO PAY FOR THE DENTAL CARE PATIENT RECEIVES HERE: (CIRCLE BELOW)

- CASH/CHECK PAYMENT
- CREDIT CARD
- DENTAL INSURANCE
- CARE CREDIT

PRIMARY INSURANCE:

SECONDARY INSURANCE:

NAME OF COMPANY _____
POLICY HOLDER _____
POLICY HOLDER SS# _____
POLICY HOLDER D/O/B _____
EMPLOYER _____

WHO REFERRED YOU TO OUR CLINIC? _____

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY? _____

PHONE NUMBER () _____

*PLEASE BE AWARE THAT PAYMENT FOR FIRST VISIT WILL BE REQUIRED AT TIME OF VISIT OUR OFFICE WILL BE HAPPY TO ASSIST IN FILING INSURANCE ON FOLLOWING VISITS.

HEALTH HISTORY QUESTIONNAIRE

DATE _____

1. ARE YOU UNDER THE CARE OF A PHYSICIAN? IF SO, WHAT IS THE CONDITION BEING TREATED? _____
2. THE NAME AND ADDRESS OF MY PHYSICIAN _____

3. HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATION RECENTLY? IF SO, WHAT WAS THE ILLNESS OR OPERATION? _____
4. DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO
A. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE	()	()
B. CONGENITAL HEART LESIONS (HEART MURMUR)	()	()
C. CARDIOVASCULAR DISEASE (HEART TROUBLE, CORONARY INSUFFICIENCY, CORONARY OCCLUSION, PACEMAKER, HEART VALVE REPLACEMENT)	()	()
D. MITRAL VALVE PROLAPSE	()	()
E. PROSTHETIC JOINTS, IMPLANTS, ETC.	()	()
F. ALLERGY	()	()
G. ASTHMA OR BREATHING DISORDER	()	()
H. FAINTING SPELL OR SEIZURES	()	()
I. DIABETES	()	()
J. HEPATITIS, JAUNDICE OR LIVER DISEASE	()	()
K. ARTHRITIS	()	()
L. GASTRIC REFLUX	()	()
M. KIDNEY TROUBLE	()	()
N. TUBERCULOSIS	()	()
O. HIGH OR LOW BLOOD PRESSURE	()	()
P. IMMUNE SYSTEM DISORDER (INCLUDING AIDS, HIV)	()	()
Q. SJOGREN'S SYNDROME	()	()
R. OSTEOPOROSIS	()	()
5. HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS EXTRACTIONS, SURGERY, OR TRAUMA? () ()
6. DO YOU HAVE ANY BLOOD DISORDER SUCH AS ANEMIA OR HEMOPHILIA? () ()
7. HAVE YOU HAD SURGERY OR XRAY TREATMENT FOR A TUMOR, GROWTH, OR OTHER CONDITION OF YOU MOUTH OR LIP? () ()
8. ARE YOU TAKING ANY DRUG OR MEDICINE WHATSOEVER? LIST: _____ () ()
9. ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO LOCAL ANESTHETICS OR ANY MEDICATION? LIST: _____ () ()
10. HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT? () ()
11. DO YOU USE TOBACCO? () ()

DATE _____

YES NO

12. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE I SHOULD KNOW ABOUT? () ()

13. WOMEN - ARE YOU PREGNANT () ()

14. DO YOU HAVE ANY OF THE FOLLOWING? OR HAVE YOU EVER HAD?

MOUTH	YES	NO		YES	NO
BLEEDING, SORE GUMS	()	()	LOOSE TEETH	()	()
UNPLEASANT BAD BREATH	()	()	SENSITIVE TO HOT	()	()
FREQUENT BLISTER MOUTH/LIPS	()	()	SENSITIVE TO COLD	()	()
SWELLING/LUMPS IN MOUTH	()	()	SENSITIVE TO BITING	()	()
BITING CHEEKS/LIPS	()	()	CLENCHING/GRINDING	()	()
CLICKING/POPPING JAW	()	()	IF SO, WHEN		
SHIFTING IN BITE	()	()	CHANGE IN BITE	()	()

15. ARE YOU PLEASED WITH THE APPEARANCE OF YOUR TEETH AND SMILE? () ()
IF NOT, WHAT WOULD YOU LIKE TO CHANGE ABOUT THE APPEARANCE?

16. LAST DENTAL EXAM _____ LAST DENTAL X RAYS _____

IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, WHAT IS YOUR RELATIONSHIP?

TO MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE A CHANGE IN MY HEALTH OR CHANGE IN MY MEDICATION, I WILL INFORM THE DENTIST AT MY NEXT APPOINTMENT.

SIGNATURE OF PATIENT DATE

SIGNATURE OF DENTIST DATE

LeFleur Dental Group

NO-SHOW POLICY

A patient is considered a no-show if he/she fails to notify the dental clinic if they cannot make their appointment at least 2 hours before their scheduled appointment. If they fail to notify the clinic, then they are subject to a **\$50 no-show-fee**. This will be charged via credit card or debit card by the clinic only at time of no show. No charges will be made otherwise.

This policy is to insure that we can properly schedule and treat our patients in a timely and efficient manner. We appreciate your understanding and please do not hesitate to ask any questions.

Signature: _____ Date: _____

Name: _____

Card Type: _____

Card #: _____

Exp. Date: _____

Security Code: _____

LeFleur Dental Group

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this form

I, _____ have received a copy of this office's Notice of Privacy Practices.

LeFleur Dental Group has my permission to speak to _____ concerning my treatment/account.

Please Print Name of Patient

Signature of Patient or Parent

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (please specify)

