# Welcome to our Practice!

Avon Dental Centre

Christopher Lefebvre, DDS
Timothy Greer, DDS

## Personal Information:

Name: _____ DOB: _____ SSN#: _____

Gender: M F Marital Status: S M D W If married, Spouse Name: _____

Address: _____ City, State, Zip: _____

Preferred First Name: _____ In case of emergency, contact: _____ #_____

**Who invited you to our Practice?** _____

## Responsible Party:

Name: _____ Relation: _____

DOB: _____ SSN#: _____ DLN#: _____

Is this person currently a patient in our Practice? Yes No

## How May We Contact You?

Home #: _____ Work #: _____Ext._____ Cell #: _____

Where do you prefer to receive calls? (Circle one above) When? Time: _____ Day: _____

Fax #: _____ Email address: _____

## Employment Information:

Employer: _____ Occupation: _____

Address: _____

City, State, Zip _____

## Insurance Information:

Name of Insured: _____ Relationship to Patient: Self Spouse Parent Other

Insured SSN#: _____ Insured DOB: _____ Policy #: _____

Insurance Company: _____ Address: _____

*Secondary Insurance?:* Yes No

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other

Insured SSN#: _____ Insured DOB: _____ Policy #: _____

Insurance Company: _____ Address: _____

## Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when by current treatment plan is completed or one year from the date signed below.

_____ _____ Date _____

Signature of Patient, Parent, Guardian or Representative Printed Name

## Health History

Physician's Name: _____ Physician's Phone #:_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin, Pondimin and Redux. Yes No

**Place a mark on "yes" or "no" to indicate if you have any of the following:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | Yes ☐ | No ☐ | Epilepsy | Yes ☐ | No ☐ | Radiation Treatment | Yes ☐ | No ☐ |
| Anemia | Yes ☐ | No ☐ | Fainting or dizziness | Yes ☐ | No ☐ | Respiratory Disease | Yes ☐ | No ☐ |
| Arthritis, Rheumatism | Yes ☐ | No ☐ | Glaucoma | Yes ☐ | No ☐ | Rheumatic Fever | Yes ☐ | No ☐ |
| Artificial Heart Valves | Yes ☐ | No ☐ | Headaches | Yes ☐ | No ☐ | Scarlet Fever | Yes ☐ | No ☐ |
| Artificial Joints | Yes ☐ | No ☐ | Heart Murmur | Yes ☐ | No ☐ | Shortness of Breath | Yes ☐ | No ☐ |
| Asthma | Yes ☐ | No ☐ | Heart Problems | Yes ☐ | No ☐ | Sinus Trouble | Yes ☐ | No ☐ |
| Back Problems | Yes ☐ | No ☐ | Hepatitis Type ____ | Yes ☐ | No ☐ | Skin Rash | Yes ☐ | No ☐ |
| Bleeding Problems | Yes ☐ | No ☐ | Herpes | Yes ☐ | No ☐ | Special Diet | Yes ☐ | No ☐ |
| Blood Disease | Yes ☐ | No ☐ | High Blood Pressure | Yes ☐ | No ☐ | Stroke | Yes ☐ | No ☐ |
| Cancer | Yes ☐ | No ☐ | Jaundice | Yes ☐ | No ☐ | Swollen Feet or Ankles | Yes ☐ | No ☐ |
| Chemical Dependency | Yes ☐ | No ☐ | Jaw Pain | Yes ☐ | No ☐ | Swollen Neck Glands | Yes ☐ | No ☐ |
| Chemotherapy | Yes ☐ | No ☐ | Kidney Disease | Yes ☐ | No ☐ | Thryoid Problems | Yes ☐ | No ☐ |
| Circulatory Problems | Yes ☐ | No ☐ | Liver Disease | Yes ☐ | No ☐ | Tonsillitis | Yes ☐ | No ☐ |
| Congenital Heart Lesions | Yes ☐ | No ☐ | Low Blood Pressure | Yes ☐ | No ☐ | Tuberculosis | Yes ☐ | No ☐ |
| Cortisone Treatments | Yes ☐ | No ☐ | Mitral Valve Prolapse | Yes ☐ | No ☐ | | | |
| Cough, persistent or bloody | Yes ☐ | No ☐ | | | | Ulcers | Yes ☐ | No ☐ |
| Diabetes | Yes ☐ | No ☐ | Pacemaker | Yes ☐ | No ☐ | Venereal disease | Yes ☐ | No ☐ |
| Emphysema | Yes ☐ | No ☐ | Psychiatric Care | Yes ☐ | No ☐ | Weight Loss, unexplained | Yes ☐ | No ☐ |

## Medications / Allergies

Please list any medications you are currently taking: _____ _____

_____ _____

Indicate allergies to the following:

Aspirin
Barbiturates (Sleeping Pills)
Codeine
Iodine
Hydrocodone (Vicodin)
Latex
Local Anesthetic
Penicillin
Sulfa
Other _____

***Women:*** Are you pregnant? Yes ☐ No ☐ Due Date _____ Are you nursing? Yes ☐ No ☐

Taking birth control pills? Yes ☐ No ☐

## Dental History

Reason for today's visit: _____

Former Dentist: _____ City/State _____

Last Dental Visit: _____ Last Dental X-rays: _____ Last Cleaning: _____

**Please circle/highlight to indicate if you have had any of the following:**

Bad breath
Bleeding gums
Blisters on lips/mouth
Broken fillings
Burning sensation on tongue
Chew on one side of mouth
Tobacco use
(If Yes, how long _____yrs.)
Clicking/popping jaw
Dry mouth
Fingernail biting
Food collection between teeth
Foreign objects
Grinding teeth
Gums swollen/tender
Jaw pain/tiredness
Lip or cheek biting
Loose teeth
Mouth breathing
Mouth pain w brushing
Orthodontic treatment
Pain around ear
Periodontal treatment
Sensitivity to cold
Sensitivity to heat
Sensitivity to sweets
Sensitivity when biting
Sores/growths in mouth
How often do you floss? _____
How often do you brush? _____

## Photographic Release

The Doctors and our Team often take digital photos in order to properly document the condition of your teeth and gums, both before and after any treatment that we render. This serves to educate both you and other patients on certain dental conditions, as well as possible results of the treatment options that we offer our clients. We may ask you for a written testimonial of your satisfaction of such procedures to discuss with other patients considering similar treatments. By signing below, I am giving Avon Dental Centre, Inc., permission to use my photos in an anonymous fashion for such educational and testimonial purposes.

Patient Signature: _____ Date: _____