PATIENT INFORMATION (Please Print) DATE: _____/______/______

NAME ____ MARRIED ___ SINGLE___
Last First MI

ADDRESS ____
Street Apt# City State Zip

BIRTHDAY _____/_____/_____ TELEPHONE _________________________________
Home# Work#
EMAIL ADDRESS _____________________________(**PLEASE PRINT CLEARLY**)
PLACE OF EMPLOYMENT ___________________________ SSN# _____-____-_____
If under 18 years old, RESPOSIBLE PARTY ________________ Relation to minor ____
ADDRESS (if different from above) ____
Street Apt# City State Zip
TELEPHONE ____
Home# Work#

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name __________________________ Telephone __________________________________
Home# Work#
Have any member of your family ever been treated in our office? _____ Name ________

ABOUT FINANCIAL ARRANGEMENTS: Payments for services are due at the time services are rendered. We accept Cash, Checks, Visa, MasterCard, or Discover.

Should a payment plan be needed, arrangements are to be made with our business staff prior to treatment. Outstanding balances older than 90 days are subject to collection by an outside agency.

APPOINTMENT COMMITMENT: Please remember, we have reserved your appointment time just for you and charges may incur for a broken appointment or an appointment canceled without 48 hours notice.

AUTHORIZATION: I hereby authorize STEVEN A. LEBEAU, DDS, to administer such and perform such diagnostic and therapeutic procedure necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to a third party and/or other health professional. I understand that I am responsible for all the cost of dental treatment. The information on this page is correct to the best of my knowledge.

SIGNATURE OF RESPOSIBLE PARTY:

____ **DATE** _______________
___Patient ___Father (or Husband) ___Mother (or wife) ___Guardian

PATIENT NAME: ___________________________________ DOB: ________________

YOUR MEDICAL HISTORY

Your physician's name _________________________________ Telephone # ________________
Approximate date of last physical examination ____
Currently under care for ____
What medications, including oral contraceptives are you taking? _______________________
____
What **ALLERGIES** do you have? ____
Penicillin/Other Antibiotics? ___Yes ___No, Latex gloves? ___Yes ___No, Are you in good general health? _________________________, Smoker? _____, Now pregnant? _____, Nursing? _____

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

Heart Problems	Blood Disease	Kidney Disease
Cancer/X-ray therapy	Heart Murmur	AIDS/HIV Positive
Surgeries	Artificial Joints/Valve	Prolonged Bleeding
Head Injury	Epilepsy/Seizures	Rheumatic Fever
Sexually Transmitted Dis	Hepatitus/Jaundice	Psychiatric care
Arthritis	Chest Pain	Drug/Alcohol Treatment
Fainting Spells	Pacemaker	Diabetes
Ulcer	Nasal Obstruction	High Blood Pressure
Liver Disease	Chronic Cough	Sinus Problems
Asthma	Bruise easily	Tuberculosis/Respiratory
Thyroid Abnormalities	Nervousness	

SIGNATURE: ____ DATE: _______________________

YOUR DENTAL HISTORY

My mouth is **A) very comfortable B) moderately comfortable C) comfortable**

PLEASE CIRCLE ITEMS THAT APPLY TO YOU:

Difficult when flossing	Pain when chewing	Headaches
Bleeding gums	Chipped/Cracked teeth	Jaw problems
Swollen gums	Temperature sensitive teeth	Pain near ears/jaws
Gum disease history	Sweet sensitivity	Clench/Grind teeth
Bad Breath/unpleasant taste	Stained teeth	Diff. Past dental surg
Mouth sores/growths	Loose teeth	Anesthetic problems

When was approximate date of your last dental examination? ______________
My last complete set of X-rays was: ______________________(Please bring all X-rays to your next appt)
I am **A) completely satisfied with the appearance of my mouth**
B) mostly satisfied with the appearance of my mouth.
C) dissatisfied with the appearance of my mouth.
I am looking for **A) Long-term solutions B) Short-term patchwork solutions** to my problems.
My previous dental experiences have been positive: **A) Always B) Sometimes C) Never**
Is anything interfering with regular dental care? **A) Fear B) Discomfort C) Scheduling time D) Financial**
What would you like us to do for you? ____

Thank you for your information. Please feel free to discuss any aspect of your care with us.

Dr. Steven A. LeBeau and Staff