



LORI LEMIRE D.M.D.

Family Dentistry
470 HIGHLAND AVENUE
COOS BAY, OR 97420
541-267-6425

PATIENT INFORMATION

Patient _____ Date _____

I prefer to be called _____

Gender: M F Age _____ Birthdate _____ Single Married Separated Divorced Other

Address _____

_____ City _____ State _____ Zip _____

Occupation _____ SS # (only if insured): _____

Employer _____ Employer Phone _____

Employer Address _____

Spouse (parent or guardian, if a minor)

Name _____

Birthdate _____ SS # (only if insured): _____

Occupation _____ Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone _____ Work Phone _____ Cell _____ Spouse's Work Phone _____

Best time and place to reach you _____ Can we call you at work? _____

In case of emergency, contact

Name _____ Home Phone _____ Work Phone _____

DENTAL INSURANCE

Who is responsible for this account? _____ Relationship to patient _____

Subscriber's name _____

Birthdate _____ Insurance ID # or SS # _____

Insurance Co. _____ Group # _____

Address _____ Phone # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____ Relationship to patient _____

Birthdate _____ Insurance ID # or SS # _____

Insurance Co. _____ Group # _____

Address _____ Phone # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Lori Lemire 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

***** PLEASE FILL OUT BOTH SIDES OF FORM. *****

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Check "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | |
|-----------------------------|--|------------------------|--|-------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis - Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abnormal Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Feet/Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Head or Neck Tumor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |

PLEASE LIST ANY ADDITIONAL HEALTH INFORMATION YOU FEEL IS IMPORTANT

HAVE YOU HAD ANY ADVERSE EFFECTS FROM DENTAL TREATMENT OR ANESTHESIA?

WOMEN: Are you pregnant? Yes No
 Are you nursing? Yes No

MEDICATIONS YOU ARE CURRENTLY TAKING

Name of Medication	Purpose of Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy name _____

ALLERGIES

- | | |
|----------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Metals | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Other _____ |

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ City/State _____ Date of last dental visit _____

Check on "Yes" or "No" to indicate if you have had any of the following

- | | | | | | |
|-----------------------|--|--------------------------------|--|--------------------------|--|
| Bad breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Clicking or popping jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain, brushing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Gums | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dry mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cigarette smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain around ear | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| How many packs a day? | _____ | Grinding teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| How many years? | _____ | Gums swollen or tender | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold/heat | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pipe or Cigar smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw pain or tiredness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to sweets | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chewing Tobacco | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity when biting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| How many years? | _____ | Lip or cheek biting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores in mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Loose teeth or broken fillings | <input type="checkbox"/> Yes <input type="checkbox"/> No | How often do you floss? | _____ |
| | | Mouth breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | How often do you brush? | _____ |