



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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## MEDICATIONS YOU ARE CURRENTLY TAKING

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

Pharmacy name \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_

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

## 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?  | _____  |