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

PLEASE LIST ANY ADDITIONAL HEALTH INFORMATION YOU FEEL IS IMPORTANT

_____

_____

_____

_____

HAVE YOU HAD ANY ADVERSE AFFECTS 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

☐ Aspirin ☐ Ibuprofen

☐ Metals ☐ Local Anesthetic

☐ Codeine ☐ Penicillin

☐ Iodine ☐ Sulfa

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