Welcome To Our Practice

We appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

ABOUT YOU

Today's Date:

Name: I prefer to be called Sex: ☐M ☐F

Marital Status: Birth date: Age: SSN#:

Home Address: City: State: ZIP:

Home Phone: Work: ext. Mobile: email:

Employer: How long there?

Occupation:

Employer's Address:

Whom may we thank for referring you?

PERSON RESPONSIBLE FOR ACCOUNT (if other than yourself)

Name: Relationship:

Billing Address: SSN:

Home Phone: Work Phone: Ext. Employer:

How long there?

Occupation:

SPOUSE INFORMATION

His/Her Name: Birth date: SSN#:

Employer: Work Phone: Ext.

Emergency Contact Name: Phone:

DENTAL INSURANCE INFORMATION

Please circle answer:

Do you have dental insurance? Yes No

If yes, please provide your insurance card (with this form) so that we can scan for our records.

HEALTH/DENTAL QUESTIONNAIRE

The cornerstone of our practice is the examination process. Our first task is to help you identify what it is that you want, both in the short term and in particular, for the long term. We feel everyone deserves to know the state of their dental health, what is moving them away from health, and the choices available to restore their oral health. If your first appointment is for a cleaning or an emergency visit, your exam will likely be cursory with limited x-rays. If you are here for a comprehensive exam, we will examine your soft tissues, teeth, gums, and chewing system. Depending on the clinical findings, we'll take appropriate x-rays and photographs.

Excellence in dentistry begins with a careful diagnosis and treatment planning. Once all your diagnostic records have been completed and evaluated, we will visit with you and review the findings, discuss your options, and together, create a personalized plan. It is important to note that once we have agreed on your plan, that quality is the constant and time is the variable. You always control how far and at what pace we'll proceed.

HEALTH HISTORY

Patient Name: _____ Birth date: _____ Today's Date: _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years? If so, for what?
   _____
4. Yes No Are you being treated by a physician now? If so, for what? _____
5. Yes No Approximate date of last medical exam? _____
6. Yes No Have you had problems with prior dental treatment? If so, explain: _____
7. Yes No Are you in moderate to severe pain now?

II. HAVE YOU EXPERIENCED:

8. Yes No Chest pain (angina)?
9. Yes No Swollen ankles?
10. Yes No Shortness of breath?
11. Yes No Recent weight loss, fever, night sweats?
12. Yes No Persistent cough, coughing up blood?
13. Yes No Bleeding problems, bruising easily?
14. Yes No Sinus problems?
15. Yes No Difficulty swallowing?
16. Yes No Diarrhea, constipation, blood in stools?
17. Yes No Frequent vomiting, nausea?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Frequent urination?
25. Yes No Dry mouth?
26. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

27. Yes No **Heart disease**?
28. Yes No **Heart attack**, heart defects?
29. Yes No Heart murmurs?
30. Yes No **Stroke**, hardening of arteries?
31. Yes No **High blood pressure**?
32. Yes No **Asthma**, TB, emphysema, other lung diseases?
33. Yes No Hepatitis, other liver disease?
34. Yes No Stomach problems, ulcers?
35. Yes No **Osteoporosis**?
36. Yes No **Allergies** to: medications, foods, latex?
37. Yes No Any other allergies: _____
38. Yes No AIDS
39. Yes No Cancer, tumors?
40. Yes No Arthritis, Rheumatism?
41. Yes No Anemia?
42. Yes No Cold sores
43. Yes No Kidney, bladder disease?
44. Yes No Thyroid, adrenal disease?
45. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

46. Yes No Psychiatric care?
47. Yes No Radiation treatments?
48. Yes No Chemotherapy?
49. Yes No **Prosthetic heart valve?** Date placed? _____
50. Yes No **Artificial joint**? Date placed? _____
51. Yes No Have you ever been told by a doctor to take antibiotics before a dental appointment? If so, please provide Dr's name & specialty: _____
52. Yes No Hospitalization?
53. Yes No Blood
54. Yes No transfusions?
55. Yes No Surgeries?
56. Yes No **Pacemaker**?

V. ARE YOU TAKING:

57. Yes No Recreational drugs?
58. Yes No Prescription medications, over-the-counter medicines (including Aspirin), natural remedies?
59. Yes No Tobacco in any form?
60. Yes No Alcohol?

Please list: _____

VI. WOMEN ONLY:

61. Yes No Are you or could you be pregnant or nursing?
62. Yes No Taking birth control

VII. ALL PATIENTS:

62. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

DENTAL HISTORY

Patient Name: _____ Birth Date: _____ Today's Date: _____

1. When was you last dental exam? _____
2. When was your last cleaning? _____
3. What do you think of your current state of dental health (circle one):

   Excellent Good Fair Poor Terrible
4. Please rate (circle):
   a. amount of fear toward dental appointments none mild moderate severe
   b. discomfort of teeth, mouth, or jaw none mild moderate severe
   c. dissatisfaction of appearance of your teeth none mild moderate severe
5. Have you had orthodontic treatment (braces) in the past? If so, roughly at what age? _____
6. What is your perception of the current state of your oral health? _____
7. What are you major concerns with your dental health? _____
8. Which of the following do you experience (circle all that apply):

Jaw pain	Jaw popping/clicking	Headaches	Neck aches
Shoulder pain	Ear pain	Sensitive teeth	clenching teeth
Grinding teeth	Change in bite	Bleeding gums	bad breath

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ Date: _____

EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. Use the following scale to choose the most appropriate number for each situation over the past two weeks. Even if you don't usually do this activity, please give your best estimate:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Situation	**Chance of Dozing or Sleeping**
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic	
Total score	

APPOINTMENTS

Because we recognize the value of your time, you can expect us to see you at the appointed time, so as to keep your time spent in our office as short as possible. Likewise, when you make an appointment with us we have reserved our time just for you and ask that you be on time. **If you cannot keep your appointment**, we ask you to give us at least **48 hour notice** so that we can give your time slot to another patient. Otherwise, our office policy is to charge an hourly rate to help defer some of the overhead expense associated with the loss of time. We believe very strongly that mutual trust and respect for each other's time will strengthen our relationship.

FINANCIAL POLICY

Unless another financial option is pre-arranged, payment in full is due the day of the treatment.

Payment Options

1. For your convenience we accept **Cash**, **Check**, **Visa**, **MasterCard** and **Discover**.
2. We also offer short and long-term financing options.
3. Feel free to discuss your financial concerns with any of our staff. We are committed to helping you remove all barriers on your journey to health.

For patients with Dental Insurance

As a courtesy, we will assist you in getting your benefits from your insurance company. For some treatment we may ask for payment in full. For other treatment, we will estimate your share of the anticipated charges and ask for that payment at the time of treatment. Should you need special arrangements for your share, please discuss this with our business manager.

Finance Charges

If your balance is not paid within 90 days of the billing date, a finance charge of 1.5% per month will be added to the account. In case of default of payment, you will be responsible for any interest on the balance due, together with any collection costs and reasonable attorney's fees incurred in the collection of this account.

AUTHORIZATION AND CONSENT

General Consent to Treatment
I agree and consent to a dental examination by Dr. LeBlanc. I understand that additional diagnostic procedures and treatment may be recommended and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatment.

Release of Information
I authorize Dr. LeBlanc to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Photography Release
I authorize Dr. LeBlanc to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs in an educational setting as well as to other patients to better explain their treatment options (as you may be shown photographs for the same reason)

My signature acknowledges that:

I understand the office policy with keeping Appointments.

I understand and comply with the Office Financial Policy.

I understand and agree to the General Consent to Treatment.

I authorize the Release of Information

Photographs taken of me may be used in a teaching environment.

I have received a copy of the office's Notice of Privacy Practices.

X _____ Date: _____
Signature of patient, parent or guardian