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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:

Birth date: _____ **oda s ate** _____

, **CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):**

1. e No **Is your general health good?**
2. e No **Has there been a change in your health within the last year?**
3. e No **Have you been hospitalized or had a serious illness in the last three**
   No **years? If** so, for what? _____
4. e No
   No r o tr at a h s a ow? or what?
5. e at of ast a a ?
6. e a o ha ro s w th r or ta tr at t? f so,
   a Are you in pain now? _____
7. e

II. **HAVE YOU EXPERIENCED:**

9. e No Chest pain (angina)?
10. e No Swollen ankles?
11. e No Shortness of breath?
12. e No Recent weight loss, fever, night sweats?
13. e No Persistent cough, coughing up blood?
14. e No Bleeding problems, bruising easily?
15. e No Sinus problems?
16. e No Difficulty swallowing?
17. No Diarrhea, constipation, blood in stools?
    No Frequent vomiting, nausea?
18. e No i i e
19. e No i i i ear
20. e No eada he
21. e No ai ti e
22. e No B rred i io
23. e No ei re
24. e No re e t
25. e ri atio r
26. e No o th
    oi t ai
    ti e
    No

. **DO YOU HAVE OR HAVE YOU HAD:**

29. e **No** **Heart disease**?
30. e **No** **Heart attack**, heart defects?
31. e **No** Heart murmurs?
32. e **No** **Stroke**, hardening of arteries?
33. e **No** **High blood pressure**?
34. e **No** **Asthma**, TB, emphysema, other lung
35. e **No** diseases? Hepatitis, other liver disease?
36. e **No** Stomach problems, ulcers?
37. e **Osteoporosis?**
38. e **Allergies** to: drugs, foods, **medications**,
39. e latex?
    6 RWHUDOOHUJLHV
    BBBBBBBBBBBBBBBBBBBBBBBBBB
    No

40. s **No** AIDS
41. s **No** Tumors, cancer?
42. s **No** Arthritis,
43. s **No** rheumatism?
44. s **No** Anemia?
45. s **No** 5 2* VRHV
46. s **No** Kidney, bladder
47. s disease? Thyroid,
    adrenal disease?
    Diabetes?

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HV 1R 3VFKDWULF" es 1R **Hospitali ation?**
HV 1R 5DGLDWLRQ WUHDWPHQW" es 1R **lood transfusions?**
HV 1R &KHPRWKHUDS\" es 1R **Surgeries?**
HV 1R **Prosthetic heart valve? When placed?** es 1R **Pacemaker?**
HV 1R **Artificial joint? When placed?**
HV 1R **Have ou ever been told b a doctor to take antibiotics before a dental appointment? f so, please provide r s name specialt**

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? _____

II. 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

Patient's signature:_____ Date:_____

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