LeBlanc
Where Dentistry and Artistry Converge

Ken S. LeBlanc, DDS, PC
Cosmetic, Restorative and **General** Dentistry
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Patient Registration

First Name: _____ Last Name: _____ Preferred Name: _____
How did you hear about us?: _____
Address: _____ Address 2: _____
City: _____ State/Zip: _____ Cellular: _____
Home Phone: _____ Work Phone: _____ Ext: _____

Sex: [ ] Male [ ] Female Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed
Birth Date: _____ Age: _____ Soc. Sec.: _____ Drivers Lic.: _____
E-Mail: _____ I would like to receive correspondences via [ ] E-mail [ ] Text
Employment Status: [ ] Full Time [ ] Part Time [ ] Retired Place of Employment: _____
Employee ID: _____ Preferred Pharmacy: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____
Address: _____ Address 2: _____
City: _____ State/Zip: _____ Pager: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
Birth Date: _____ Soc. Sec.: _____ Drivers Lic.: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec.: _____ Insured Member ID: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec.: _____ Insured Member ID: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

Dental History

How long since your last dental visit? _____ Former dentist and city? _____
How long since your last complete dental examination (including complete dental x-ray series)? _____
How long since your teeth have been cleaned professionally? _____
How often do you usually have your teeth cleaned professionally? _____
Any history of:

[ ] Bleeding Gums
[ ] Tender or Swollen Gums
[ ] Loose teeth
[ ] Sensitive teeth
  [ ] Cold
  [ ] Hot
  [ ] Sweets
  [ ] Biting pressure
[ ] Sensitive areas in your mouth
[ ] Rough, irregular or bothersome areas areas
[ ] Food collecting between teeth
[ ] Burning tongue
[ ] Teeth or fillings staining or yellowing
[ ] Sore jaw muscles or joints
[ ] Pain or ringing in the ears
[ ] Headaches
[ ] Tired jaws
[ ] Daytime or nighttime clenching or grinding of the teeth
[ ] Lip or fingernail biting
[ ] Orthodontic treatment
[ ] Periodontal (gum) treatment
[ ] Endodontic (root canal) treatment
[ ] Crown (cap) or bridges
[ ] Partial or full removable dentures
[ ] Food collecting under bridges or dentures
[ ] Teeth shifting or moving

Please check if you have been thoroughly instructed in the following:
[ ] Proper brushing and flossing techniques [ ] Cause and prevention of dental decay [ ] Cause and prevention of periodontal (gum) disease
Please list any specific complications with dental treatment: _____

Please describe any past bad experience: _____

Please check one:

1. My mouth is:
   [ ] very comfortable
   [ ] moderately comfortable
   [ ] uncomfortable

2. I
   I am
   [ ] think the appearance of my mouth is excellent
   [ ] satisfied with the appearance of my mouth
   [ ] dissatisfied with the appearance of my mouth

3. I
   [ ] will do anything to keep my natural teeth
   [ ] want to keep my teeth, but have a certain budget of time and money that I am willing to invest
   [ ] don't care whether I keep them or not

4. I
   [ ] have set goals for my oral health with my previous dentist
   [ ] want to set goals concerning my dental health
   [ ] don't care about setting goals concerning my dental health

5. I have
   [ ] put dentistry for myself and my family high on my priority list
   [ ] put dentistry for myself and my family low on my priority list
   [ ] it's on my list, but it's hard to find

6. I think my present state of dental health is
   [ ] excellent
   [ ] good
   [ ] somewhere between good and poor
   [ ] poor

What is your chief concern or reason for this visit? _____

What are some questions about dentistry and oral health that you have never had adequately answered? _____

Please check off the areas below which you have questions about or are interested in learning more about.

[ ] Periodontal disease (cause and prevention)
[ ] Gum recession
[ ] Halitosis (bad breath) (cause and preventions)
[ ] Dental decay (cause and prevention)
[ ] Cosmetic dentistry
  [ ] Bonding
  [ ] Porcelain veneering
  [ ] Bleaching
  [ ] Porcelain jacket crowns
[ ] Dental implants for replacement of single or multiple missing teeth
[ ] Bonded or porcelain inlays, onlays or crowns (caps) as alternatives to fillings
[ ] Fixed and removable bridges
[ ] T.M.J. (temporomandibular joint) disorders
[ ] Dental malocclusion (abnormal bite)
[ ] Premature wearing-away of the teeth due to grinding
[ ] Toothbrush abrasion
[ ] Removable bridges or dentures
[ ] Orthodontics
[ ] Wisdom teeth (3rd molars)
[ ] Protective athletic mouth guards
[ ] Mouth ulcers
[ ] Sealants
[ ] Fluoride
[ ] Root canal (Endodontic) therapy
[ ] Pregnancy and oral health
[ ] Dental care for infants and small children
[ ] Nitrous oxide sedation
[ ] Hospital dentistry
[ ] Dental Insurance
[ ] Financing dentistry

Are you allergic to any of the following? [ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Local Anesthetics
[ ] Other. If yes, please explain: _____

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MEDICAL HISTORY

PATIENT NAME _____ BIRTH DATE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If yes, please explain _____-
_____
Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain _____
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain _____
Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain _____
Do you take, are have you taken, Phen-Fen or Redux? O Yes O No If yes, please explain _____
Are you on a special diet? O Yes O No If yes, please explain _____
Do you use tobacco? O Yes O No If yes, please explain _____
Do you use controlled substances? O Yes O No If yes, please explain _____

Women: Are you
Pregnant/trying to get pregnant? O Yes O No Taking Oral Contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following? **Check all that apply**
O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics
O Other If other, please explain _____

Do you have, or have you had, any of the following: **Check all that apply**

O AIDS/HIV Positive
O Alzheimer's disease
O Anaphylaxis
O Anemia
O Angina
O Arthritis/Gout
O Artificial Heart Valve
O Artificial Joint
O Asthma
O Blood Disease
O Blood Transfusion
O Breathing Problem
O Bruise Easily
O Cancer
O Chemotherapy
O Chest Pains
O Cold Sores/Fever Blister
O Congenital Heart Disorder
O Convulsions
O Cortisone Medicine
O Diabetes
O Drug Addiction
O Easily winded
O Emphysema
O Epilepsy or Seizures
O Excessive Bleeding
O Excessive Thirst
O Fainting/Dizziness
O Frequent coughs
O Frequent Diarrhea
O Frequent Headaches
O Genital Herpes
O Glaucoma
O Hay Fever
O Heart Attack
O Heart Murmur
O Heart Pace Maker
O Heart Trouble/Disease
O Hemophilia
O Hepatitis A
O Hepatitis B or C
O Herpes
O High Blood Pressure
O Hives or Rash
O Hypoglycemia
O Irregular Heart Beat
O Kidney Problems
O Leukemia
O Liver Disease
O Low Blood Pressure
O Lung Disease
O Mitral Valve Prolapse
O Pain in Jaw Joints
O Parathyroid Disease
O Psychiatric Care
O Radiation Treatments
O Recent Weight Loss
O Renal Dialysis
O Rheumatic Fever
O Rheumatism
O Scarlet Fever
O Shingles
O Sickle Cell Disease
O Sinus Trouble
O Spina Bifida
O Stomach/Intestinal Disease
O Stroke
O Swelling of Limbs
O Thyroid Disease
O Tonsillitis
O Tuberculosis
O Tumors or Growths
O Ulcers
O Venereal Disease
O Yellow Jaundice

Have you ever had any serious illness not listed above? O Yes O No If yes, explain _____

_____

Comments:_____

_____

_____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN_____ DATE _____/_____/_____

SMILE EVALUATION

Hold a full face mirror 12" - 14" from your face. Smile to show your teeth; take the time to observe your teeth carefully. Then answer the following questions. (It is helpful to have a friend ask you the questions).

_____ Date _____

Last *First* *Middle*

1. Do you like the overall appearance of your teeth, your smile? ❑ YES ❑ NO
   If NO, please describe _____
   _____

2. Do you consider that your teeth are in good alignment (straight)? ❑ YES ❑ NO
   If NO, please describe _____

3. Do you have spaces between your teeth that you don't like? ❑ YES ❑ NO
   If YES, please describe _____

4. Do you like the color of your teeth? ❑ YES ❑ NO
   If NO, please describe _____

5. Do your teeth have unattractive stains? ❑ YES ❑ NO
   - ❑ Tobacco stains
   - ❑ Coffee/tea stains
   - ❑ Discolored fillings
   - ❑ Tetracycline stains
   - ❑ Silver filling stains
   - ❑ Other _____

6. Do you like the shape of your teeth? ❑ YES ❑ NO
   If NO, please describe _____

7. Do you think that your teeth are attractive? ❑ YES ❑ NO
   - ❑ chipped
   - ❑ overlapping
   - ❑ protruding
   - ❑ excessively worn
   - ❑ hidden
   - ❑ artificial looking

8. Do you like the way that your upper and lower teeth come together? ❑ YES ❑ NO
   If NO, please describe _____

9. Do you consider that your existing fillings or dental work is unattractive? ❑ YES ❑ NO
   If YES, please describe _____
   _____

10. Do you think that your gums are unattractive? ❑ YES ❑ NO
    - ❑ swollen
    - ❑ excessively receded
    - ❑ reddened
    - ❑ crowns are ill-fitting
    - ❑ bleed easily
    - ❑ difficult to clean between teeth

11. What would you like to change the most in the appearance of your teeth, your smile?
    _____
    _____
    _____
    _____
    _____

(Over)